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Therapeutic Community

Psychiatrie in der Gemeinschaft
Gemeinschaft in der Therapie

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Wiesbaden, 21–26 August 1967

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Symposium on Psychotherapy in a Community Context

J. RUESCH, San Francisco, Cal.

Participants

P. A. H. BAAN, Geneva; M. JONES, Melrose; F. KNOBLOCH, Prague;
H. STROTZKA, Vienna; H. THOMSTAD, Oslo

From notes taken during the Symposium and from copies of the presentations provided by some of the participants, the Chairman has, upon request of the Editorial Board, compressed three hours of discussion into a brief summary. That such a 'tour de force' can in no way do justice to the superb contributions of the participants and the lively discussion from the floor is to be deeply regretted but unavoidable under the circumstances. Here, then, are some of the highlights of the discussion.

The Chairman introduced the topic by pointing out that the population explosion and the increasing number of people who avail themselves of psychiatric services limit drastically the number of cases that can be seen in traditional long-term therapy. Therapeutic talent can be used more effectively if the total situation in which a behavior disturbance occurs is considered. Depending upon the circumstances, therapeutic measures may take the form of crisis interventions in the family, job or agency consultations, conjoint therapeutic sessions in the doctor's office, group psychotherapeutic meetings, or participation in a therapeutic community. These therapeutic measures fit into the modern technological civilization with its large-scale social organizations. The modern social order is characterized by the rapid disappearance of the person orientation and the progressive ascendance of the system orientation, and the psychiatrist is being forced into the role of change agent for smaller social groups. Therefore, his theoretical focus is moving from individual to group, from psychopathology to social pathology, and from psychodynamics to social dynamics. Concomitantly his methods of intervention are shifting from the traditional one-to-one relationship to multiperson interaction, and from treatment to prevention. Within the framework of the person orienta-

tion the psychotherapist asked 'What kind of person is this?' In the modern system orientation he asks 'What kind of situation am I confronted with?' The concept of situation, of course, includes persons, machines, the physical environment, and the social transactions that people are involved in. The task of the modern therapist, then, not only is directed at coping with conflicts within the individual but has been extended to include conflicts between individuals, between person and group, and between group and society. To manage conflicts at these various levels of complexity, the therapist must, of course, be thoroughly familiar with individual psychology, psychopathology, psychodynamics, human interaction, communication, group structure, value systems, economics, and other aspects of the social order. The modern therapist has in effect become a social engineer.

The changed role of the psychotherapist was illustrated by KNOBLOCH's experiences with psychoneurotic patients in Prague. As soon as a new patient requires treatment, individual interviews are arranged and contact is established with both a social worker and a psychiatrist. Individual psychotherapy is not continued for long because it is regarded as a loss of time, from both a diagnostic and a therapeutic point of view. The patient attends open group meetings where he meets not only new patients but also patients who are convalescent and patients who have returned from the therapeutic community unit located outside of the city. If the patient does not improve during several meetings, he is sent to this State Farm, where he lives with about thirty other patients and works on the place. Interpersonal relationships, and especially the transference aspects, are analyzed in detail in group meetings. Isolation of the patient from his habitual milieu and temporary residence in this therapeutic community form part of the treatment; it enables the psychiatrist to observe the patient in an artificial community where his neurotic behavior can be closely studied and where he is exposed to corrective experiences. The impact of group living is more efficient than any comparable individual therapy, particularly during the first stages of treatment. During the patient's stay at the Center, the spouse is invited to attend a group composed of marital partners. After the patient's return to Prague, he and his spouse continue to participate in various groups, and if the patient is well motivated for further psychotherapy, and needs it, he can continue in a small, closed group or in individual psychotherapy for a longer period of time.

STROTZKA corroborated the idea that milieu therapy and social measures are considerably more effective than individual therapy, a conclusion that he based on his experiences with refugees and the uprooted. Studies

in camps for displaced persons organized under the auspices of the United Nations led to a number of conclusions, namely, that the number of persons in any one camp should not exceed 300 to 500; that the site should not be isolated geographically; that the organization should be characterized by self-administration; that children should attend the local schools; and that inmates should be taught the language of the host country. If the region that harbors refugee camps is prosperous, as was the case in the decade from 1955 to 1965, the economic conditions may often be more contributive to rehabilitation than the therapeutic measures themselves. In arranging the assignment of tasks among the various professional specialties, casework and group work would seem to fall into the domain of the social worker while severe pathology would require the attention of the medical psychotherapist. Frequently the less highly trained workers approach complex family problems with more common sense than experienced psychotherapists, who are used to a one-to-one relationship and who tend to feel uncomfortable in group situations. In these camps, the experienced therapist will at times select some persons for individual psychotherapy. An example in question was a smaller group of about two hundred young Hungarians who needed some analytically oriented psychotherapy to cope with their specific problems. These youths came from disturbed families, were themselves disturbed, and hoped to solve their problems by leaving the country. Their pervading infantile personality traits were characterized by low frustration tolerance, inability to form new human relations, failure to engage in productive work, and sometimes by acts of delinquency. The need for close therapeutic relations proved to be greatest in cases where the family structure had been the least cohesive.

Baan gave an admirable overview of the state of social and community psychiatry in various nations and reported a number of interesting experiences from his work as Chief of the Mental Health Section of the World Health Organization. Further examples of the relationship between individual and group and of the ways in which an individual leaves the community at large and is admitted to the hospital were contributed by Thomstad from Oslo. Apparently the family-centered approach of meeting the prospective patient proved helpful, particularly when commitment was considered. A joint interview with patient and relatives, often in their homes, prepares the patient for a variety of group meetings. Sometimes families may be hospitalized together, and the nurse's function then is to support the family unit and to participate in family therapy and husband-wife groups.

JONES addressed his remarks to the subject of training and social learning. He deplored some of the modern educational trends which induce mental health personnel to act as consultants, to play a supervisory role with agency personnel, and to have relatively little contact with the client or patient. He suggests than in the three years of formal residency training a young psychiatrist should participate in programs that take responsibility for the mental health of a region or population. A hospital unit that represents such a small sample of the larger society can do much to prepare the young psychiatrist for work outside of the training center. The hospital ward represents a community where psychiatric personnel attempt to bring about improvement in a group of psychiatrically 'sick' people. A ward meeting, with all patients and staff present, affords an opportunity to examine problems of living in that particular social unit. If such a meeting is followed by a staff review, the interaction which occurred during the ward meeting offers an opportunity to study what was said and done, and why. The various disciplines – psychiatry, social work, nursing, and so on – may view the same situation in different lights because of their different training and their particular personalities. A setting of this kind encourages interaction and ensures that discussion of inter-staff roles, role relationships, and conflicts will have some bearing on the treatment of patients. In JONES' opinion, this is a much gentler approach to T-Group training, or Sensitivity training, than is a formal training group made up of staff, with the purpose of examining relationships within the group. Sensitivity training is much easier to initiate after the staff have been exposed to ward meetings and reviews for some time. Training for social interaction (sociotherapy) rather than training for psychotherapy thus is the goal of such programs.

The multidisciplinary team, operating within the hospital structure, can extend its influence into the community. By widening the concept of psychiatric illness to include the family, the team can contact a variety of relatives living in the community. The identified patient is more likely than not only a symptom of family disequilibrium that may represent a somewhat unsatisfactory attempt on the part of the family to remain a functioning unit. The fact that many family group workers now meet all members of the family, including the children, together, helps to get away from the need to label one family member as 'sick'. The same can be said for activities centering around social problems such as family planning, marriage guidance, and other therapeutic and prophylactic endeavors. The concept of primary prevention emphasizes the need for help at a time

when the individual is feeling isolated and overwhelmed. This calls for a coordinated community approach of a kind as yet little understood. The role of the spouse or other family members in such a situation may be vital if illness is to be prevented. It would seem that, as yet, the psychiatrist cannot hope to be involved in situations of this kind and must rely on contact with his colleagues in general practice, or with public health nurses and other members of the social services. It is well possible that ultimately the psychiatrist, with his medical or psychoanalytic background, will have a relatively unimportant role to play in community psychiatry and that the word psychiatry may best be eliminated from such a description.

In summarizing the transactions of the meeting, RUESCH pointed to the changing role of the physician. If the older medical scheme was characterized by an identified patient, an identified doctor, and an identified disease, the new scheme of things is characterized by a problem population, a health team, and a potential health risk. If in the older days clinical medicine was concerned with treatment and care of acute conditions, in recent years it has turned its attention to chronic diseases and residual states. In these latter conditions, treatment seems less important than housing, care, human relations, and rehabilitation for work. At this point, the medical task of treatment merges with the governmental responsibility for the welfare of the citizen and the individual need for self-realization and human relations. Within such a modern framework the older academic departments have lost their significance. The convergence of psychiatry, sociology, psychology, and anthropology has led to the development of the behavioral sciences that deliver information regarding the structure of human behavior. The more dynamic disciplines such as personology, psychotherapy, counseling, organization, communication, administration, and management share in common the tendency to steer, organize, or change social behavior, and they seem to merge into a new field concerned with social operations. If the behavioral sciences combine with the operational disciplines and the bio-medical fields to care for the population's health, the physician must learn to work side by side with professionals of varied backgrounds. He must learn to co-operate with private and government agencies, with groups, and with individuals. The management of the total situation thus has become the new task of medical psychotherapy in the modern world.

Author's address: J. RUESCH, M. D., Dept. of Psychiatry, University of California School of Medicine, *San Francisco, Cal. 94122* (USA).

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Implementation Barriers to Community Mental Health Programs

A. A. Woloshin and H. C. Pomp, Hines, Ill.

Northwest Subzone, Illinois Department of Mental Health,
John J. Madden Mental Health Center, Hines, Ill.
(Director: A. A. Woloshin, M. D.)

An increasingly complex society with its rapid urbanization and technological expansion has been accompanied by attempts to quantify and rationalize the social system through the application of cybernetics, standardized planning concepts, operations research and systems theory.

The need for sounder conceptual systems and more complete information for decision-making is universally recognized, yet recent attempts to utilize quantified data and standardized concepts in the field of mental health have resulted in many benefits and problems. Since the benefits of such procedures have been widely developed and disseminated (see Bertalanffy [1] for a systems theory and operations research bibliography), the authors will address themselves to barriers in conceptualizing and implementing mental health programs which have significantly detracted from the achievement of mutually shared objectives. It is important to emphasize at the outset that there is general consensus with respect to the objective of providing a means for early detection and treatment of emotional disability through community mental health efforts. Differences of opinion are focused on the means for accomplishing this objective. Our comments are concerned with the United States program in mental health. For this reason broader application to other countries must be generalized by the listener based on his individual knowledge and experience.

Expenditures for mental health purposes at the Federal, state and local levels have increased markedly. For example in 1965 state and local governments spent approximately $ 115 million for community mental health services. This compares with $ 6 million spent by state and local

governments for these services in 1952 and $ 37 million in 1959 [2]. Similar upward trends have been evidenced in operation of public mental hospitals which now amounts to $ 1.3 billion per year.

In order to establish mental health clinics and services, the United States Public Health Service, through the National Institute of Mental Health, allocated $ 6.7 million in the 1966 fiscal year and $ 50 million for the 1967 fiscal year. Total expenditures for mental illness from all sources now amount to over $ 2 billion per year [3].

Stimulated by a desire to effectuate a maximum utilization of such new resources, a major planning effort was initiated. The Congress of the United States authorized planning funds for detailed studies of the mental health needs and resources of each of the states. Bolstering the national government's interest in planning was legislation that precluded the granting of Federal mental health funds to any state which had not submitted a comprehensive plan for review and acceptance by the Federal authority. Local communities, cities, counties, states as well as national groups have begun large scale coordination and integration of existing efforts to determine service gaps and unmet future needs in planning new programs.

The rapid growth and proliferation of planning efforts has resulted in the parallel development of a full time occupation, a life career related to such endeavors. In effect, we have created the professional planner as a career occupation and provided him with an inordinate degree of power for evaluating current mental health programs, establishing priorities for allocation of resources and shaping the characteristics and dimensions of future programs. Since plans must be implemented and resources applied by individuals who have not been directly involved in the process of planning and resource-priority setting, there is a widening bifurcation between the planners and implementers-operations. While each state prepared a state-wide plan, this plan was primarily developed by professional planners on a state level including limited consultation and liaison with individuals responsible for program operation.

Although state-level mental health authorities were being encouraged to develop comprehensive plans geared to their specific needs, the Federal government had already imposed predetermined constraints. One such constraint was the rigid community mental health center model. This model defined comprehensive mental health services as having five basic components: in-patient service, out-patient service, emergency service, partial hospitalization as well as consultation and education. The Federal government was so committed to this model that it became an integral

part of subsequent legislation which funded the construction and staffing of community mental health centers [4]. Not only did this legislation insist upon a predetermined service model, but it also required that a community center serve a catchment area of not more than 200,000 people. Although it is conceivable, for example, that one stable community of reasonable wealth and well developed health and welfare services might require a community mental health center for 300,000 people, such a program would not be funded. Another community of relative anomie and high unemployment might require a mental health center for every 50,000 population. This also would not be funded. Programmatically a community may require only two components of service and may appropriately serve a population which is larger than 200,000. While such criteria for funding mental health programs may have been soundly conceived initially by Federal statisticians, it rarely met individual needs of local communities. Once again the planners imposed inflexible guidelines on the implementers.

In spite of the surface development of advisory panels and individual consultation efforts, it is the authors' contention that this separation between planning and implementing groups is not only continuing but appears to be widening as well. From the previously stated observations the following hypothesis was developed:

> *Hypothesis:* The greater the degree of separation between planners and implementers, the greater the degree of error between needs to be met and the program required to meet them.

1. One of our critiques of the professional planning group is that it does not have available a sufficiently wide range or depth of experientially or experimentally validated concepts or data upon which to draw. It is, in effect, several steps removed from the problems and potentialities of operational programs. The planners, therefore, often rely on hypothetical constructs and generalized demographic data which often do not adequately reflect significant aspects of the situation for which they are planning.

While demographic data are a significant variable in any planning process, such data must be related to an implementation model which takes into consideration the meaning and interpretation of these data for a particular community. Consideration of such aspects as the history of a community, the nature of its institutions, communication patterns, power legitimizing factors and other impressionistic variables are part of a con-

figuration of elements which will determine the success or failure of a particular program. In essence, a community can be described as a sample of one that is in all probability unique and different from another community possessing similar demographic characteristics. Generalization of predetermined models have built-in liabilities, not the least of which is the lack of development of a framework of transferability of concepts from one setting to another. Good intent is not the same as good sense. Many programs fail, not because their ideas or hypotheses are invalid, but more related to the fact that the ability to transfer the idea to a new arena of action has not been adequately conceptualized and planned.

The professional planner with his armamentarium of charts, graphs, data banks and expensive data processing equipment is prone to overlook those aspects of soft information which are critical to a reliable and valid understanding of a specific community. Too often the planner fails to consult those individuals who are part of the operating structure of a community [5]. These persons may be able to provide impressionistic data and attitudinal information that is essential to any effective planning effort and implementation system. Unless the people who can commit mental health resources are centrally involved in the structure of planning and resource distribution, integrated goal setting and achievement potential will not be in accordance with the needs of the community.

II. A second critique is that the professional planner, being several steps removed from the actual or projected operational structure, often becomes a victim of his own attempts at scientific facade. Even though a projected delivery of services system appears to be internally consistent, this is not in fact a measure of its validity. It may be more accurate to state that it reflects the needs of the planners for order and closure rather than the needs of the population to be served. It is perfectly feasible to predetermine a mental health center model based on hypothetical constructs (i. e. maximum population census, necessary components of programs, etc.) and impose such a model in a standardized manner for all communities. The authors believe that the failure to consider local variables will provide the antithesis of what is sought and severely limit the attainment of the projected patient services.

III. In their haste to blueprint the plan for the brave new mental health world, professional planners often overlook the possible alignment between existing mental health programs and those that are projected. Frequently planners do not build upon the strengths of existing mental health facilities and erroneously transfer proven competency in the

general hospital area to anticipated competency in mental health programming. One of our primary axioms is that ideas flow where money is and it is not without cautious scepticism that we have noted that the funding for mental health centers has been awarded in the main to the local purveyors of medical services. The types of services offered in a mental health program may require major structural and programmatic changes dramatically different from those in general hospitals. To be explicit, it appears that what is covert in the planning procedure is the assumption that competency in the general hospital area can be transferred to mental health programs. At best this is a questionable assumption since the provision of mental health care in a general hospital does not involve the full utilization of such professionals as psychologists, psychiatric social workers, rehabilitation counselors, special educators and others. Without providing adequate means for integrating such professionals into the medical hospital's administrative and treatment structure, the community mental health approach would be seen as provision of care for individuals without dealing with the community and effectively utilizing other resources outside of the hospital. Although the hospital sees itself as a community resource, its intake policy is controlled by individual physicians who admit patients with an 'illness' for which they are the primary therapist. We might call this unitary framework the one man – one disease model. In this system a sick person seeks help because of a symptomatic problem and help is provided by a practitioner who tends to see a maladaptation or a disease process developing from a specific etiological factor. Conversely the community mental health field tends to adhere to a rehabilitation-adjustive framework which deals with a multiplicity of factors poorly understood, all of which impinge on an individual. These various factors are both causative as well as potential treatment agents depending upon the techniques and modalities employed by skilled practitioners. Thus, the current trend which makes the general medical-surgical hospital the nucleus for comprehensive community mental health programs places experienced mental health personnel and facilities (in the same geographic area) in a secondary position with little impact on policy.

IV. In the United States there exists a multiplicity of state-owned and -operated mental hospitals. The vast majority of these facilities have become repositories for society's rejects and in general, can be described architecturally and programmatically as ranging from medieval Asylum Gothic to Contemporary Schizophrenic. The physical plants are deteriorated, staffing is below minimally accepted ratios and treatment programs

often nonexistent. In recent years, many of these facilities have begun the Herculean task of entering the 20th Century. Such efforts at self improvement have met with little support from the professional planners. Resource allocations to accomplish this objective have been quite minimal in contrast to budgeting and staffing for new mental health facilities.

For example, the Federal government will generously provide millions of dollars to fund and staff a new community mental health center while Hospital Improvement Program grants to upgrade an existing psychiatric institution are limited to $ 100,000 per year, renewable for ten years. While new money is rapidly channeled to the new facilities, the poorly funded state hospitals continue to treat the overwhelming majority of mental health patients. In analyzing this situation it appears that the following three factors are primary in the mind of the planners:

A. State hospitals cannot be significantly improved.

B. That the imposition of the new models (i. e. the new community mental health centers) will obviate the need for state hospitals.

C. That professional planners tend to add new facilities which reflect the new model rather than modifying existing facilities. New facilities provide greater visibility, are purer conceptually and appear to represent a quicker procedure for accomplishing the planner's goals.

The projected problem inherent in such an emphasis is that we may create two worlds of mental health care. The modern and better staffed facility will be available to the select few who meet stringent intake criteria. This facility becomes a show case, treating selected cases, while the majority of people needing mental health services will receive a small fraction of the resource potentiality while being relegated to state hospitals. There was an expectation in the community that the new facility would be a panacea for all mental health problems, but recent statistics [6] indicate areas which possess high levels of professional staff and agency concentration refer a proportionately higher percentage of cases to state mental hospitals than those areas where professional staff and agencies are more scarce. If this is true, the planners of community mental health centers must recognize the limitations of such operations and begin to deal adequately with other institutions by reallocating resources on the basis of realistic performance.

Little in the way of conceptualizing how existing facilities can change has come from professional planners. This is an area that needs further development and should be seen as a bridge between planners and implementers. Since institutions change over time, one of the areas that requires

further elaboration is that of understanding the nature of institutional change in order to control its speed and direction for public social welfare policy.

The authors have been involved for the past two years in an attempt to modify a traditional, programmatically weak state mental hospital. This effort involved developing concepts of planned social change relative to readiness for change and capacity of the institution to change. Included were functional decentralization for better service on a programmatic basis, increasing staff-patient ratios as well as physical plant renovation [7]. This endeavor is seen as the first of many steps to elevate the quality of patient care to a level commensurate with other public and private facilities. The results of the first year are remarkable and recently the hospital was accredited by the Joint Commission on Accreditation of Hospitals, the major standard-setting agency for all American hospitals. This accomplishment is a significant one since only 58.8 % of all American hospitals – public and private – are accredited and only 33.3 % of public psychiatric facilities have met Joint Commission standards[1].

It is the authors' belief that such state hospitals can and should be improved programmatically and physically as a major priority item in any mental health service delivery system. We further believe that unless such improvement takes place, the United States will be developing a double track system which will not accomplish the projected goal of quality patient care for all its citizens requiring mental health service. The current priority emphasis on new institutions must be revised if the goal for rapid, readily accessible, effective services is to be achieved.

V. A major area of daily frustration relates to the inflation of community expectations in relationship to the time-resource sequence and the promise-performance outcome. In this era of gaps – credibility gaps, missile gaps, generation gaps – we have managed to produce the expectation gap. Information regarding delivery and performance of a mental health program can be likened to a discordant stereophonic sound system in which each of the two tracks is providing a different message. The professional planner's sounds are generally of a utopian nature in which promises are made on a conceptual loudspeaker without clear

[1] Data from correspondence files of the American Psychiatric Association, Washington, D. C. Of all psychiatric hospitals, public and private 182 of 483 are accredited. In the state and public psychiatric hospital category 106 of 318 are accredited. (Jan. 1967) There are 7127 registered hospitals in the United States all of various types. Of this number only 4204 were accredited in January, 1966.

interpretation of such problems as time schedules, program planning, resource development and implementation. Without such a signal, community expectation is increased to a 'here and now' level and the operational staff who cannot deliver the conceptualized level of tunes as broadcast, is therefore defined as the 'bad guys' or 'incompetents'. The small gains achieved through considerable effort and sacrifice are tuned down and made to seem inconsequential compared to the noise emanating from the professional planner.

The authors believe that we should not disseminate our future objectives unless we fully clarify the phasing plan and resources needed for achievement. Otherwise, we run the risk of developing programs by sloganeering. This results in loss of confidence and eventually withdrawal of community support. Currently the planners make promises for the delivery of services far in advance of the implementer's ability to develop them. While there is always a time lag between the initiation, legitimation and implementation stages, some consideration must be given to reasonable limitations.

VI. While the actual practices of planners do create serious barriers to implementation, it should be recognized that their overall approach with its macrocosmic considerations makes an important contribution to the mental health field. The planner has three major areas of concern:

A. Forecasting the probable outcome if no change is made in the current policy with regard to the delivery of mental health resources and the expected impact of such stagnation.

B. Reviewing the assumptions he has developed and making a forecast regarding the effect of changes in current policy and reallocation of resources.

C. Estimating changes that take place with this allocation of resources and recommending modifications in policy which will meet the new goals.

The means which the planner chooses to attain these goals should depend as little as possible on preconceived ideas and as much as possible on probable results. Specifically, the planner is task-oriented and thereby makes his recommendations for change of policy and resource allocation on a broader macrocosmic action-oriented base. The planner, by definition, must deal with a specific task or project. He must develop necessary kinds of data, often in areas where little information has existed previously, and propose alternative solutions which project beyond the 'here and now' to an uncertain future. The planner's charge is an overwhelming one and must be accomplished on a time-limited basis.

In sharp contrast to the task-oriented planner, the implementer is modality-oriented. The mental health professional (implementer) is involved in developing the means of achieving the planner's goals. However, in dealing with individual patients he makes decisions based on the skills of his discipline which limit the achievement of the major tasks. The therapist bases his decisions on the modalities of treatment rather than the broader tasks projected by the planner. From this there develops a programmatic approach which is usually relevant to a modality of treatment. Such an approach may severely limit the number and kind of people to be served in a mental health program. Thus, the task that was originally envisioned by the planner is actually subverted by the implementer who limits his effectiveness by screening potential patients on the basis of treatment techniques, rather than needs.

Initially the planner rejected the existing system of mental health care and proposed community programs as an alternative. However, it is our contention on the basis of current planning efforts and the critiques offered, that not all patients will be treated by the proposed community programs. At the operational level clinical practices, disciplinary approaches and a generalized microcosmic outlook will act as a screen and eliminate those predetermined patients defined as 'unmentionable', 'undesirable' and 'untreatable', who have always been relegated to state hospitals. This community mental health system, as envisioned in the United States, has yet to find a place for these individuals and at the same time there has been little concern for revitalization of those places which have been their domiciles. While there should be an increase in monies for all mental health programs, by comparison money flows at an alarming rate to the new programs while the state hospitals are virtually neglected. The inherent differences in the two institutional prototypes (community center vis-à-vis hospital) is that the two worlds previously mentioned are not in themselves incompatable; what is needed, however, are alternatives for the patients mentioned who are currently not considered by planners.

Summary

The preceding presentation has reviewed some of the barriers to the implementation of effective mental health programs. In consideration of such a critical analysis it is instructive to recall that throughout the history of the mental health movement, periods of progress have been followed

by retrenching and regression. It is our hope that this presentation will delineate some of those areas which require further exploration and begin a thoughtful discussion which will lead to a rapprochement between the planners and implementers. Unless this is done, the planner-implementer cleavage could negate the high expectations which the community mental health movement holds.

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Author's address: Arthur A. Woloshin, M. D., and H. C. Pomp, Northwest Subzone, Illinois Department of Mental Health, John J. Madden Mental Health Center, 1200 South First Avenue, *Hines, Ill. 60141* (USA).

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Psychiatric Aftercare in a General Hospital
A System of Prevention in the Community

S. L. SAFIRSTEIN

Department of Psychiatry, Institute of Psychiatry,
The Mount Sinai Hospital, New York, N. Y.
(Director: M. Ralph Kaufman, M. D.)

It was as a medical student that I first came across a statement that one can cure every gonorrhea except the first one. Mark Twain put the same idea differently when he said it is rather easy to stop smoking, he had done it a hundred times. These two statements portray the concept of chronicity and the difficulty of changing it. They also indicate states of relative quiescence and flare-ups or states of remissions and exacerbations.

The present approach to mental illness is that it is a chronic condition. This applies to neuroses as well as to psychoses [7]. Treatment must concern itself first and foremost with the acute exacerbations which disrupt completely the life of the individual and his family and to try to bring about a state of remission.

Aftercare is the stage of treatment that has as its objective to help the patient to return to the state of functioning that existed prior to the acute flare-up [7, 8, 9]. It is the purpose of this paper to suggest that aftercare can play a role in preventing future exacerbations, nip them in the bud or abort them. It can also reduce psychiatric emergencies, as the majority of them occur in individuals who had previously been hospitalized [1]. A system of such prevention is offered.

PASAMANICK *et al.* [5] demonstrated that the majority of acutely ill schizophrenics can be effectively treated in their homes and thereby avoid hospitalization. He further showed that the same patients can be maintained at home once the florid stage of their illness had subsided. What he did was to combine treatment and follow-up or care and aftercare in the home of the patient.

When hospitalization becomes inevitable it is important that it be as short as possible, that it does not disturb the patient's functioning longer than necessary and that it avoid the ankylosing effects of institutional living [8]. Aftercare takes over when the patient returns home and follows him with whatever help he needs for as long as it is indicated. However, even aftercare can become a way of life with many patients whose personality make-ups are of a passive-dependent nature. Many aftercare clinics are cluttered with patients who keep coming year after year, and who firmly believe they could not get along otherwise. It is therefore felt that prolonged aftercare may have effects similar to those of prolonged hospitalization and may aid and abet dependent trends in dependent individuals. Formal aftercare should therefore also be of short duration.

HORNSTRA and WILKINSON [2] demonstrated that about 40 % of patients who attended an aftercare clinic for a number of years and were receiving medication, could be safely discharged. However, by discontinuing and dropping them, it seems that one is throwing out the baby with the bath water. It is of paramount importance to find a way to allow the chronically ill person to live his own life and yet make available to him the needed help if and when an incipient state of an acute exacerbation is about to break out.

In an attempt to accomplish this, the concept of institutional transference is being employed [6, 10]. The phenomenon of attachment to an institution, a hospital, an establishment, has been observed and described by many. The concept of institutional transference is modeled on the psychoanalytic concept of individual transference which is a genetic phenomenon of feelings toward parents transferred later on to others and in this case to an impersonal object.

Transference is one of the most powerful psychic phenomena known, and institutional transference has similar implications. A general hospital in the community is particularly apt to become the recipient of institutional transference. A psychiatric department in a general hospital benefits from the fact that it is located in the midst of the community and the implication that mental illness is considered on a par with any other type of illness [3, 4].

These are important considerations when one thinks how different the attitude is toward a mental hospital. The latter is usually seen as a removed place in which people are 'put away' to be isolated and forgotten. The general hospital carries with it the charisma of giving and caring which is a part of the long standing tradition of medicine. People go to a general

hospital to get well. The doctors, nurses and ancillary personnel are held in high esteem. There is hardly a problem in getting a patient to accept hospitalization in a general hospital. Any mention of a mental hospital brings on pangs of deep-seated anxiety, feelings of incurability and hopelessness.

The Mount Sinai Hospital of New York is a 1337 bed hospital founded in 1852. In the United States this is considered an old hospital. It was built by the efforts of the Jewish population and was situated in the heart of the Jewish community. Its first name was The Jews Hospital. With the neighborhoods of New York changing their ethnic character, the area was later on occupied by Italians and now by Puerto Ricans and Negroes.

The hospital has had a high reputation for excellence of service and teaching and its medical staff has carried a tradition of high medical standards. Numerous advances in medicine have been made at Mount Sinai and it can be said that it is widely known and respected. It is usually included in the list of the 10 best hospitals in the United States.

Its Department of Psychiatry is of more recent vintage. An ambulatory division was started during World War I and a 22 bed ward was opened in 1946. At the end of 1962 the department moved to a new building and the services were enlarged to include 125 beds, a day and night Center. From its beginnings the department has been a pioneer in the movement of introducing psychiatry to general hospitals. It has a staff of about 150 part time volunteer psychiatrists most of whom are psychoanalytically trained and oriented. A training residency in the department is considered a desirable appointment by many doctors who embark on the career of psychiatry and applications far exceed the 42 available positions.

The aftercare clinic [7, 8] receives the vast majority of patients discharged from the wards and the day and night Center. The clinic is the largest in the outpatient department and carries about 400 active patients. All modalities of treatment are employed according to indications but emphasis is on psychotherapy. Drugs are next in importance. Psychotherapy is mostly supportive in nature and in some selected cases the residents are encouraged to try a more intensive approach. Twenty five first and second year residents in training work with aftercare patients and have the opportunity to follow some patients for as long as two years in more intensive psychotherapy.

Although its theoretical framework is psychoanalytic, no psychoanalysis is being utilized. A large percentage of our residents, however, choose to enter psychoanalytic training after they have finished their residency.

Most of the aftercare patients are prepared for a brief course in the aftercare clinic. They are followed through their return home, resumption of their occupations or started on the path of rehabilitation as the case may be, and discharged. If they are on drugs and need them on a continuous basis, they either receive them in the clinic or from their family doctor.

It is in this relatively short course of aftercare treatment that the groundwork for prevention is being prepared. It is the same resident who follows his patient on the ward and in aftercare assuring a continuity of services and a doctor-patient relationship, both so important in the treatment and management of the patient. It is within this relationship that certain factors have to be ascertained; is the transference mostly individual or is the institutional variety predominant?

Although all diagnostic categories are represented among our patient population, the diagnosis of schizophrenia predominates. It is a known fact that schizophrenics cannot stand closeness with anyone, including their therapists. They need distance and this must be respected. Often such patients have to break away from therapy because an inexperienced therapist insists on closeness. It is this type of patient who relies more on institutional transference and less on individual transference. Although there is ample evidence that the patient internalizes his therapist and often identifies with him, genuine closeness and intimacy is something the schizophrenic cannot afford to risk and therefore it is rare [10].

What is safe is his impersonal reliance on the mighty institution onto which he prefers to externalize his feelings of gratitude and dependence. In this way he is not obliged to enter into any interpersonal ties fraught with feeling which are most threatening to him. This kind of relationship between a person and an institution is similar to a relationship between an individual and a god and many patients express their godly reverence for Mount Sinai. They live under the umbrella of the powerful, godlike hospital. They believe they will be taken care of by the hospital when they need it, which is the case. At this point severeal generations of families have been cared for by the hospital and transference to it has spread to a sizable segment of the population in the community.

When this kind of feeling is diagnosed, the therapist adopts an affirmative attitude and prepares his patient for discharge. The preparation consists of a reiteration that the aftercare clinic and the hospital will take care of him should he need them again and an explanation to the patient in terms of his particular condition as to when he should return. He is in-

structed to watch out for his particular prodromal symptoms and feelings and to contact the clinic if they appear. He is cautioned not to wait too long before calling for help.

When a patient develops strong emotional ties with his therapist and it becomes apparent that there is a strong positive individual transference present, the resident begins a different kind of preparation for discharge. He begins to stress the importance of the hospital and the clinic to the patient indicating that the residents come and go while the hospital and the clinic are always there to take care of him. Separation anxiety which is a stumbling block to any termination of treatment is anticipated and worked with rather early in aftercare therapy. The purpose is to substitute institutional transference for individual transference or at least to dilute the latter. The rest of the preparation is the same as for the former category of patients.

Actually, what is portrayed by every patient is a mixture of both individual and institutional transference with a predominance of one or the other, depending on the nature of the patient's illness. It can be said generally that in patients with psychotic defenses institutional transference tends to prevail.

What happens to our discharged patients? It would seem that the clinic would be swamped with patients clamoring for readmission. This has not been the case. The average readmissions rate to the aftercare clinic over a 3 years' span has been 14.7 % of the closings (table I).

As far as rehospitalizations are concerned, the average over the same 3 years' period has been 8.6 % of the closings (table II).

In the absence of a controlled experiment and considering the relatively short period of time during which this system has been tried out, the readmissions' rate to both the aftercare clinic and the inpatients' services have been low. The aftercare clinic has appointed itself as the guardian

Table I

	1964	1965	1966	Total
Cases closed	140	224	178	542
Readmissions to aftercare clinic	23	19	38	80
In percentages	16.4 %	8.4 %	21.4 %	14.7 %

Table II

	1964	1965	1966	Total
Cases closed	140	224	178	542
Readmissions to inpatient services	16	18	24	58
In percentages	11.4 %	8 %	14 %	10.7 %

of the discharged patients and has committed itself to take care of them if and when reoccurrence of acute illness threatens to erupt. In a true sense the aftercare clinic has become the watchdog and caretaker of a multitude of people who maintain invisible ties with it and with the hospital. In most cases the simple knowledge and feeling that help is available if needed, is sufficient to keep them on their own. After all, no matter how sick a person is, he still has healthy aspects one of which is the need and the wish to be on his own if this is at all possible.

There is a small group of patients who cannot function on their own and must rely on someone at all times. Such individuals usually have developed symbiotic relationships with a person on the outside to which they return after hospitalization. Still, there are a few who have no one to rely on on the outside and these have to be seen in aftercare for prolonged periods of time.

When it is no longer possible for the patient to function on his own outside the hospital, he returns for help and the clinic puts all of its resources at his disposal. Most of the time one or several sessions of supportive psychotherapy is all that is needed to help him regain his equilibrium and he is again discharged. Sometimes he is in need of counseling in terms of his job, housing, school or other social problems and brief casework therapy is supplied. If longer psychotherapy and/or drugs are needed it is made available and if rehospitalization is indicated, either full or part time is used.

Summary

A system of secondary prevention has been established in an aftercare clinic of a general hospital. The charismatic aspect of the general hospital and its standing in the community have been utilized to effect early discharges and to maintain the patient in the community.

S.C.E.R.T., West Bengal
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The discharged patients keep invisible ties with the aftercare clinic and the hospital and believe it will take care of them if and when they need it. The concept of institutional transference explains the nature of the attachment to and the belief in the hospital.

Statistical data indicate that this system reduces the need for readmissions to the aftercare clinic and/or to the inpatient services.

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Author's address: S. L. SAFIRSTEIN, M. D., 1100 Park Avenue, *New York, N. Y. 10028* (USA).

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Psychotherapie im Rahmen von Institutionen sozialer Sicherheit

H. Strotzka, Wien

Als vor 17 Jahren die obligatorische Krankenversicherung für Arbeiter und Angestellte in Wien unter ihrem Chefarzt E. Tuchmann auf Initiative von Hans Hoff sich entschloss, ein psychotherapeutisches Ambulatorium einzurichten, war die Skepsis nicht nur bei den Gegnern der Psychotherapie gross, sondern vor allem die Psychoanalytiker stellten keine gute Prognose. Manche vermuteten, dass überhaupt keine Patienten kommen würden, andere nahmen an, dass solche Ambulanzen mit unheilbar chronifizierten Neurosen und Charakterstörungen überlaufen würden. Kaum jemand konnte sich die Technik und Arbeitsweise eines solchen Ambulatoriums vorstellen.

Damals gab es zwar schon das Beispiel des Zentralinstitutes für psychogene Erkrankungen in Berlin und einige andere Vorläufer; es fehlte aber noch eine allgemeine Kenntnis der Erfahrungen über die breite Anwendung der Psychotherapie im Rahmen des Health Service in England.

Inzwischen ist die Institution, über die hier berichtet wird, von einem Therapeuten auf sieben angewachsen (fünf für Erwachsene, zwei für Jugendliche), und es werden derzeit vier Freudianische Vollanalytiker beschäftigt. Die Psychotherapeuten arbeiten im Durchschnitt an fünf Wochentagen, vier bis fünf Stunden pro Tag, in einem Angestelltenverhältnis, völlig unabhängig von der Patientenfrequenz. Jeder Therapeut ist frei in der Anwendung der Technik. In der Regel jedoch wird ein Patient eine halbe Stunde in der Woche gesehen, wobei allerdings Behandlungszeiten bis zu mehreren Jahren vorkommen. Die überwiegend angewandte Methode ist eine Form der psychoanalytisch orientierten Kurztherapie,

die eine gewisse Ähnlichkeit mit der fokalen Psychotherapie aufweist, wie sie MALAN [2] aus der Schule BALINTS an der Londoner Tavistock-Clinic beschrieben hat. Der Verfasser vertritt den Standpunkt, dass Psychotherapeuten, von einer gewissen Qualifikationsstufe an, nicht in ein bestimmtes Technikschema gedrängt werden sollen. Er selbst wendet neben der oben erwähnten Methode unverändert weiter auch klassische nichtanalytische Techniken an, wie das autogene Training, Suggestivmethoden (vor allem eine bei uns entwickelte Form der Narkohypnose, wo sehr kleine Mengen eines Kurznarkotikums sehr rasch mit einfachen suggestiven Formeln intravenös injiziert werden) sowie Beratungen, die der case-work-Technik sehr nahekommen oder ihr sogar völlig entsprechen. Er steht auf dem Standpunkt, dass die Verschiedenartigkeiten der Person, der sozialen Situation und der Art der Erkrankungen es unmöglich machen, ohne differentialdiagnostische Erwägung und sehr individualisierte und elastische Indikationsstellung eine einzige Technik uniform anzuwenden. Andere Mitarbeiter haben sich im Gegensatz dazu auf eine bestimmte Methode spezialisiert, die sie fast ausschliesslich anwenden. Viele Therapeuten scheuen sich auch nicht, medikamentös zu behandeln, nicht nur bei den Psychosen, die zunehmend in der Klientel der Ambulanz auftauchen, sondern auch bei Neurosen, oft bewusst suggestiv im Sinne eines Placeboeffektes, um etwa den Zugang zu einem Patienten zu finden, für den die Verordnung eines Medikamentes allzu sehr zur Erwartungsvorstellung einer wirkungsvollen Behandlung gehört. Aus verschiedenen Gründen sind die Schwächen der Institution ungenügende Dokumentation der Fälle und mangelnde Teamarbeit.

Der Einsatz von Psychologen und Sozialarbeitern hat sich (bei den erwachsenen Patienten) nicht recht bewährt. Einerseits ist die Zahl der Therapeuten zu klein für die Ausnützung einer klinischen diagnostischen Psychologie und nachgehenden Fürsorge, andererseits entsprechen solche Tätigkeiten noch nicht dem Anpassungsgrad der Gesamteinrichtung, die noch zu sehr von den Vorstellungen einer klassischen kurativen Medizin dominiert wird. Bei weiterem Anwachsen der Therapeutenzahl und einer zu erhoffenden Klimaänderung in der Institution wäre natürlich die klassische Teamarbeit (Arzt, Psychologe, Sozialarbeiter) zweifellos anzustreben.

Der im folgenden gebotene Erfahrungsbericht bezieht sich auf Grund der oben angeführten Mängel im wesentlichen nur auf die eigenen Ergebnisse und berücksichtigt die Beobachtungen der anderen Psychotherapeuten nur peripher.

Der grundsätzliche Eindruck, der aber von allen Mitarbeitern verschiedenster theoretischer Herkunft und auch von den Vertretern stark abweichender Techniken bestätigt wurde (insgesamt sind mehr als 10 Therapeuten im Laufe der Jahre in der Einrichtung tätig gewesen), war überraschenderweise die geringe Einschränkung der therapeutischen Wirksamkeit durch die kostenlose Behandlung. Ohne Zweifel hat FREUD seinerzeit richtig gesehen, als er das finanzielle Opfer für eine wesentliche Voraussetzung erfolgreicher Neurosebehandlung erklärte. Nun umfasst die Klientel einer solchen Ambulanz einen immer grösser werdenden Prozentsatz anderer Krankheitsgruppen. Neurosen im engeren Sinne machen derzeit nur ein Drittel der Gesamtfälle aus, und es ist bei der gegebenen Situation (und wahrscheinlich auch prinzipiell) eine volle oder auch nur teilweise Finanzierung der Therapie durch Patienten mit Psychosen, Charakterstörungen aber vielleicht auch psychosomatischen Erkrankungen kaum zu erwarten. Während noch vor einigen Jahren ein Behandlungskostenbeitrag für die Psychotherapie ideologisch für den Kostenträger undiskutabel gewesen wäre, ist ein solcher Gedanke heute wahrscheinlich auch den Arbeitnehmervertretern in der Kassenleitung durchaus nicht mehr so fremd. Der Verfasser würde jedoch heute mehr denn seinerzeit zögern, einen solchen Vorschlag zu machen, da es undenkbar ist, nur bei Neurosen einen solchen Kostenbeitrag einzuheben. In den Besprechungen von Übertragung und Gegenübertragung, die sich in einer solchen Einrichtung oft zwanglos über die personale Arzt-Patientenbeziehung hinaus auf Wesen und Funktionsweise der Ambulanz und der sozialen Sicherheit überhaupt ausdehnt, zeigt sich ganz deutlich, dass die Motivverstärkung zur Therapie, die sich bei der Privathonorierung durch den Wert, der investiert wird, ergibt, zum Teil durch andere Einsichten und Erlebnisse ersetzt wird. Dazu gehört z. B. der dem sonstigen Bild von Arzt-Patientenbeziehung in der Sozialversicherung fremde Zwang zur Pünktlichkeit, aber auch die Einhaltung von Zeitzusagen durch den Therapeuten und gewisse Tendenzen zur Terminisierung, da der Zustrom zu einer solchen Ambulanz naturgemäss wesentlich grösser ist als deren Leistungsfähigkeit.

In diesem Zusammenhang erhebt sich die sehr wesentliche Frage nach Selektion und Wartelisten. Das in den meisten ähnlichen Einrichtungen übliche Prinzip einer Selektion in der Regel unter Zuziehung psychologischer Teste mit vorheriger starrer Prognose- und Indikationsstellung wurde von uns nie angewendet. Der wahre Grund war ein finanzieller und organisatorischer. Wir arbeiten an drei Stellen der Stadt und begannen an jeder Stelle mit nur einem Therapeuten. Die Einrichtung einer zentralen

Aufnahme- und Sichtungsstation lag unter diesen Umständen ausserhalb unserer technischen Möglichkeiten. Auch hier kann man sagen, dass inzwischen eine solche diagnostische Abteilung, die dann die ausgewählten Patienten je nach den Möglichkeiten auf die Wartelisten der einzelnen Therapeuten setzt, derzeit denkbar wäre. Auf Grund unserer Erfahrung scheint uns das jedoch jetzt gar nicht mehr so wünschenswert. Wir haben immer wieder in ausländischen Instituten gesehen, dass, offenbar einer Variation des Parkinsonschen Gesetzes folgend, die Tendenz besteht, solche Siebungsstationen im Vergleich zu den eigentlichen Therapiemöglichkeiten wachsen zu lassen. Die offizielle Begründung dafür ist in der Regel das Bedürfnis nach Wissenschaftlichkeit, da nur die objektive Untersuchungsmöglichkeit und die empirische Verlaufskontrolle durch diese, in der Regel von den erfahrensten Therapeuten und von klinischen Psychologen besetzten Einrichtungen, eine Objektivierung der Psychotherapiearbeit gestatten könnte. Es hat dies zwar seine Richtigkeit, aber man kann sich andererseits nicht ganz dem Gefühl entziehen, dass hintergründig dabei die Tendenz zum Ausdruck kommt, starke Personal- und Energiekräfte der belastenden und frustrationsreichen direkten Arbeit am Patienten zu entziehen. Es gilt dies ganz besonders für solche Institutionen, wo die diagnostische Arbeit mehrere Tage in Anspruch nimmt. Die Verlässlichkeit und Gültigkeit von *Diagnose* und *Prognose* und *spezifischer Indikationsstellung* ist derzeit noch nicht so gross, als dass ein solcher Aufwand für die Praxis gerechtfertigt wäre. Bei uns ergibt sich diese Trias zwanglos aus der direkten Arbeit mit dem Patienten und dem Eindruck der ersten therapeutischen Sitzungen. Anders ist dies allerdings, wenn durch solche Selektionsstellen tatsächlich wissenschaftlich an einer Verbesserung der Situation gearbeitet wird. Dann ist natürlich jeder Aufwand berechtigt.

Wir versuchen durch Kontakt mit den zuweisenden Stellen (es ist überraschenderweise unverändert ein relativ kleiner und überschaubarer Kreis von Ärzten und Anstalten, die die Majorität der Patienten zuweisen) die Zahl der überwiesenen Patienten nicht allzu gross werden zu lassen. Schwieriger ist es allerdings, die spontan Kommenden in Grenzen zu halten. Wir versuchen kurz abzuschätzen, ob es möglich ist, den Patienten auf die in der Regel nur Wochen oder maximal wenige Monate dauernde Warteliste zu setzen oder ob einer der Therapeuten den Patienten wenigstens ganz kurz zu sehen hat, um eine Entscheidung darüber zu treffen, ob er sofort eingeschoben werden muss oder ob eine andere Massnahme (etwa stationäre Aufnahme) angezeigt ist. Es wird daher praktisch jedem

zugewiesenen Patienten die Chance eines Therapiebeginnes geboten. Ich bin immer wieder davon überrascht, dass die üblichen prognostischen Kriterien (Art der Diagnose, Lebensalter, Ichkräfte, bisherige Lebensbewährung, soziale Situation, Therapiemotivation und Einstellung etc.) keine verlässlichen Rückschlüsse auf den Therapieverlauf gestatten. Von vielen Seiten wird zum Beispiel die *Chronizität* eines Zustandes für sehr wichtig gehalten. Wir sehen nun gar nicht selten, dass selbst bei einer Manifestationsdauer von mehr als 10 Jahren der völlig neue überraschende Zugang zur Person des Patienten, wie es die Psychotherapie darstellt, einen dramatischen therapeutischen Effekt einleiten kann.

Diese Schilderung darf natürlich nicht einen allzu optimistischen Eindruck vermitteln. Denn selbstverständlich verführt die opferfreie positive Zuwendung der kostenfreien Therapie den Patienten dazu, sich in ihr häuslich einzunisten, und es neigen viele Therapeuten ebenfalls dazu, unendliche Therapien ohne wesentliche dynamische Veränderungen zu pflegen. Eine ständige Kontrolle der Gegenübertragung sollte derartige Entwicklungen vermeiden lassen, und manchmal wäre eine milde Intervention eines Supervisors recht wünschenswert.

Im Rahmen eines Kurzreferates kann auf die Therapietechniken und ihre Erfolge nicht eingegangen werden. Wir haben dies an anderer Stelle getan [3, 4, 5]. Leider verfügen wir nicht über die eindrucksvollen katamnestischen Untersuchungen, wie sie DÜHRSSEN [1] aus dem wesentlich grösseren Berliner Institut berichtet hat. Es liegt dies vorwiegend daran, dass wir nicht wagen können, unsere alten Fälle postalisch einzuberufen, da bei einem erstaunlich hohen Prozentsatz die Angehörigen, vor allem die Ehegatten, nicht über die Behandlung informiert wurden. Von den Faktoren, die das unmittelbare Therapieergebnis beeinflussen, sei nur erwähnt, dass ganz eindeutig jene Patienten die beste Erfolgschance haben, die auf Empfehlung ehemaliger, erfolgreich behandelter Patienten kommen. Die schlechteste haben jene, die von Kontrollärzten zugewiesen werden. Man hat Grund, der Schilderung der Patienten zu glauben, dass die Form dieser Zuweisung sich etwa so abspielt, dass *expressis verbis* oder indirekt zum Ausdruck gebracht wird: «Ihnen fehlt sowieso nichts, gehen Sie zur Psychotherapie!»

Noch ein Wort zur Gruppentherapie. Nur einer der Mitarbeiter führt eine Psychosengruppe. Die Aufstellung von Neurosengruppen scheiterte bis jetzt an der Ambivalenz der Institution, der Therapeuten, vor allem aber der Patienten, die die Gruppe als Kollektivierung ablehnten. Das Klima wird sich in dieser Beziehung allerdings wohl verbessern.

Man kann unsere Erfahrungen kurz so zusammenfassen, dass unter der Voraussetzung verbesserter Supervision, Dokumentation, Teamarbeit und natürlich einer ganz wesentlichen Ausweitung, die von uns entwickelten Formen der psychotherapeutischen Behandlung in der Sozialversicherung sich ausgezeichnet bewähren und eine gute Voraussetzung für eine wirkliche Versorgung der Bevölkerung darstellen. Wir möchten dabei besonders die Vielfalt der angebotenen Methoden und die Elastizität der Indikation als *Vorteil* unterstreichen, weil sie auch einen Wechsel des Therapeuten gestattet, wenn sich ein Patient besser für eine andere Behandlungsweise eignet. Wir haben mit solchen Therapeutenwechseln sehr gute Erfahrungen gemacht.

Selbstverständlich wäre das tatsächliche Bedürfnis nach Psychotherapie bei einem Versichertenstand von etwa einer Million (mit Angehörigen) ganz wesentlich grösser, als wir anbieten können. Man muss sich bei Planungsgriffern allerdings sowohl vor einem allzu grossen Schematismus als auch unkontrolliertem Wunschdenken hüten. Bei realistischer Erwägung der Möglichkeiten würde ich für die Wiener Gebietskrankenkasse 20 Psychotherapeuten im *Rahmen von Ambulatorien* für sinnvoll halten.

Manchen wird diese Zahl von *einem* Psychotherapeuten pro 50 000 *Köpfen* der Bezugsbevölkerung überraschen und viel zu niedrig erscheinen. Wenn man nämlich nur 10 % psychotherapiebedürftiger Störungen annimmt, wäre dies ja eine «case load» von 5 000 Patienten. Dabei ist aber zu bedenken, dass der Grossteil dieser 10 % aus psychogenen Reaktionen besteht, die eine sehr gute Spontanremissionstendenz haben, wenn keine iatrogenen Schädigungen gesetzt werden. Ich stehe weiterhin auf dem Standpunkt, dass unverändert die Hauptlast der Behandlung psychosozial Gestörter von den Praktikern und Fachärzten der freien Praxis getragen werden sollen. Facheinrichtungen haben nur bei einer ausgewählten Klientel, wo die allgemeinen Versorgungseinrichtungen versagen, ihren Platz. Man muss sich aber schon wegen des Mangels an ausgebildeten Psychotherapeuten beschränken. Alle Psychotherapieschulen klagen – zumindest in Österreich – über einen zu geringen Nachwuchs. Der Anreiz, sich für diese schwierige und bei unseren sozialen Gegebenheiten durchaus nicht einträgliche Disziplin unter grossen Opfern an Zeit und Geld ausbilden zu lassen, ist sehr gering. Es ist ohne Zweifel notwendig, viel mehr als dies bis jetzt der Fall ist, die Psychotherapieausbildung zu einem integralen Teil des Psychiatriestudiums zu machen. Ausserdem ist es notwendig, das gesamte Medizinstudium in dem Sinne zu reformieren, dass auch der praktische Arzt und die Fachärzte aller anderen Gebiete ein

besseres Verständnis für ihre psychosozial und psychosomatisch gestörten Patienten aufbringen, und lernen, einfache psychotherapeutische Behandlungsmethoden zu beherrschen, respektive iatrogene Schäden zu vermeiden [6].

Das Klima für solche tiefreichende Veränderungen der Einstellungen der medizinischen Fakultät und der gesamten Ärzteschaft ist vorläufig jedoch noch sehr schlecht. Ein führender Administrator der Krankenkasse hat kürzlich in einer Diskussion nicht ohne Berechtigung den Standpunkt vertreten, dass es nicht Sache der Einrichtungen sozialer Sicherheit sein kann, bei einer solchen Entwicklung voranzugehen. Bei konsequenter Anwendung der bisher erarbeiteten sozialpsychiatrischen Ergebnisse müssten nämlich über das ganze Land verstreut ambulante Psychotherapieeinrichtungen geschaffen und das Honorarsystem so reformiert werden, dass die Bedeutung des ärztlichen Gespräches gegenüber allen möglichen Manipulationen wieder angehoben wird. Es wären auch eine ganze Menge grundsätzlich neuer Einrichtungen nötig, wie psychosomatische Konsiliarstellen an allgemeinen Krankenhäusern und sehr differenzierte Rehabilitationseinrichtungen. Letztlich wäre der Geist der sozialen Sicherheit vom Versorgungsgedanken in Richtung auf eine psychohygienische Grundhaltung (also im Sinne von Vorbeugung und Rehabilitation) hin zu verändern. An sich würde eine solche Entwicklung völlig der der körperlichen Medizin des 19. Jahrhunderts parallel laufen, wo es ja auch bereits selbstverständlich geworden ist, dass Vorbeugung und Hygiene, Impfungen und dergleichen, sich besser bezahlt machen, als rein kurative Medizin.

So bedeutende Umstellungen können aber von den Einrichtungen der sozialen Sicherheit nicht erwartet werden, wenn die Öffentlichkeit und die Autoritäten der Medizin sie nicht eindeutig stark unterstützen. Davon sind wir allerdings noch weit entfernt. So kann ich etwa für Österreich derzeit eine Entwicklung wie in der Bundesrepublik, nämlich die Honorierung der Psychotherapie beim praktizierenden Nervenarzt gar nicht mit gutem Gewissen empfehlen, weil der Grossteil dieser Nervenärzte vorläufig noch keine psychotherapeutische Ausbildung besitzt und mit einer solchen Massnahme nicht nur die Gefahr der Charlatanerie, wilder Analysen, sondern auch recht wesentlicher iatrogener Schädigungen gegeben ist.

Ich habe über die Erfahrungen mit einer psychotherapeutischen Ambulanz im Rahmen einer Pflichtkrankenkasse berichtet. Es ist möglich und notwendig, Psychotherapie für Krankenversicherte und wenig bemittelte, breite Bevölkerungskreise sinnvoll anzubieten. Es bestehen dabei

kaum mehr theoretische Schwierigkeiten. Die praktische Realisierung scheitert bis jetzt allerdings noch an der konservativen Haltung der überwiegenden Majorität, vor allem der massgebenden Mediziner, und hier müsste unsere Arbeit zuerst ansetzen.

Zusammenfassung

Erfahrungen und Probleme in einer psychotherapeutischen Poliklinik der Wiener Gebietskrankenkasse (Pflichtversicherung von Arbeitern und Angestellten mit 1 Million Mitgliedern) werden besprochen. Es erfolgt keine Selektion, die Methoden variieren stark von psychoanalytisch orientierter Psychotherapie bis zum Autogenen Training, die häufigste Behandlungsdauer und -frequenz beträgt eine halbe Stunde pro Woche. Die Therapie ist für die Patienten kostenfrei, die Therapeuten arbeiten meist halbtags bei fixem Gehalt. Die Ergebnisse sind trotz grossen Schwierigkeiten insofern nicht schlecht, als zumindest viel Iatrogenie vermieden wird. Das Problem psychosozialer Störungen in unserer Zeit wird jedoch nur gelöst werden können, wenn alle Ärzte eine bessere Ausbildung in Psychodynamik bekommen werden.

Summary

The experience gained and the problems encountered in a psychotherapy policlinic belonging to the Vienna Area Sickness Benefit Scheme (compulsory insurance scheme for wage-earners and salaried employees with a million members) are discussed. There is no selection of patients; methods used vary widely, from analytically oriented psychotherapy to 'autogenic training'; the most usual rate and duration of therapy is half an hour a week. Treatment is free for the patient; the therapists mostly work half-time for a fixed salary. Results, despite considerable difficulties, are not bad; a great deal of iatrogenic sickness, at least, is avoided. The problem of psychosocial disorders at the present time will only be solved, however, when all doctors are better instructed in psychodynamics.

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Adresse des Autors: Dr. H. STROTZKA, Daringergasse 16/24, *A-1190 Wien* (Österreich).

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Psychotherapy in the Computer Age

J. RUESCH, San Francisco, Cal.

We are living in the atomic age. Although our thinking is deeply influenced by contemporary technology, we have not as yet fully understood, much less accepted, the psychological and social changes associated with the new sources of energy, the exploration of space, and the computer revolution [16]. Many of the conflicts existing between nations, organizations, and people can be traced to a discrepancy between technology and social order on the one hand and between social order and individual thinking on the other. Characteristic of the old order is the person orientation that has dominated the Western world since the beginning of history. Characteristic of the new order is the system orientation that has come into being since the advent of the space age [45].

The world of the past was structured around *people*. Technology was subservient to immediate human needs; space was organized to satisfy the individual's sense of ownership and territoriality; history was written around the personalities of the leaders; laws defined personal responsibility; the social order was designed to regulate human relations; and control consisted of making people do what those in power desired.

The new world is structured around *systems* made up of man, machine, and the environment surrounding both [5]. Technology no longer serves people exclusively; it also is subservient to robot and gadget. Persons no longer own land; they lease and share in rotation whatever facilities they need, and spatial arrangements have become collective and discontinuous. Man has ceased to be king pin in the modern order. The individual has become anonymous, and history is being written in terms of social movements or technological achievements. Our laws [27] no longer can be

structured around persons because within gigantic organizations responsibilities are allocated not to individuals but to groups. Responsibility thus has become collective and has been extended to include long-term effects of technological innovations. For these reasons, modern rules and regulations tend to be written around products or situations rather than around people. This new orientation thus is concerned with man-machine interaction, and control measures are geared towards keeping the whole system, with all its animate and inanimate components, operative.

And now for the details.

Technological civilization and human affairs

The transition from the person orientation to the system orientation has brought profound changes to man's *psychological structure* [36]. From rugged individualism, excellence in performance, and emphasis upon personal experience we have moved to notions of group interdependence, popularity, and shared experiences [15]. The sense of personal identity [13] has given way to the concept of organizational identity [44], and lifelong roles are being replaced by time- and situation-bound roles [52]. As the march of technology progresses, people and places become more alike, while machines and technical tasks become more specialized. Adaptation to this multiplicity of situations requires an attitude of detachment [19, 49] which vividly contrasts with the older involvement in possessions, ownership, commitment, and stable human relations. From survival of the fittest we have moved to survival of the most adaptive to organization and machine [1].

Human relations, of course, reflect the character of the individual, and *vice versa.* If the old order was characterized by small communities where human contact with the same people was frequent and contact with outsiders sparse, the new order requires contact with many people who are seen but occasionally [35]. Homogeneous groups have given way to heterogeneous groups and contact restricted to the ingroup is being replaced by short-lasting contacts with the outgroup. With this widening in number of casual acquaintances goes a diminished contact with the extended family. Generations no longer live together in the same house. Often they even live in different states or on separate continents. The core family remains together as long as the children are small, but thereafter there is a tendency for the members to regroup with different partners [4].

These changes in interpersonal relations have had a significant influence upon human *communication*. In the past, speech, dress, comportment, and manners were adapted to the conditions of the ingroup; and teachers, elders, or appointed officials kept values and symbolic systems stable and uncontaminated. Today, the situation is reversed. With our multiple contacts and heterogeneous groups we must employ universal symbols of the pidgin English variety. These are inaccurate but serve the purpose of approximate communication with casual acquaintances. The control that formerly was extended over language and behavior now focusses upon the symbolic systems of science and technology [37]. In the modern world the chemical formulas, electrical diagrams, statistical denotations, and mathematical symbols are strictly controlled and internationally understood [48]. The IBM card is presumed to be inviolable.

Automation, computers, and the modern social order are based upon the progressive *separation of man from his message*. Before the invention of writing, the sender and his message were inseparable in that the human voice carried but a few hundred feet and could not be preserved. With the advent of writing [29], the manuscript could be separated from the scribe, but because it was hand-written it still bore a personal imprint [39]. With the invention of electronic tape, the spatial and temporal separation of man from message became complete. Isolated from its human source, the message became a product that could be manipulated at will [12]. Therefore, there exists a considerable distrust of statements emanating from government or corporations that have message manipulating facilities at their disposal [37]. This phenomenon is currently known as the 'credibility gap'.

Once message and author were separated, communication became the subject of scientific inquiry. The *theories* upon which modern communication engineering is based are manifold, but the two best known are information theory [43] and cybernetics [51], or the theory of control and communication in the animal and the machine. The notion of feedback – the incorporation of effects of a discrete action at the source – has had a revolutionary effect upon the behavioral sciences in that for the first time in history the dichotomy between mind and body or between information and action has been successfully overcome. The notion that both man and machine are controlled through information bridged the age-old gap between the animate and the inanimate worlds.

The concept that *action is controlled by information* makes people interchangeable with machines. New autonomous robots capable of

complex actions take their place alongside human beings, and through intimate contact people imperceptibly shape themselves in the image of the machine. Gradually relinquishing what was characteristically human [17], man has begun to create facilities for the machine. If the old world was made to accommodate plants, animals, and people, the new world is designed to accommodate inanimate structures [28]. Our dwellings, once surrounded by nature, now stand in the midst of masses of cement, brick, and asphalt; and vertical architecture has replaced the traditional horizontal building style [40].

In the first *industrial revolution,* machines extended the scope of our skeletal and sensory systems and largely abolished the manual worker, his skills, and the hand-made product. In the second industrial revolution, automation abolished the factory worker. In the third industrial revolution, the computer, by extending the scope of our brain and decision-making apparatus, will abolish the clerical workers who at present are occupied with manual information processing [42]. Office automation now is beginning to gnaw away at our oversized bureaucracy, and eventually it will eliminate the typist, the file clerk, and perhaps even the secretary [41].

The codification of data in computers requires a different kind of social *organization* [18]. The solo operator is vanishing, work has become highly specialized, and tasks are distributed among people who operate in teams. As the person is decreasing in importance, the sense of individual responsibility becomes limited; considerations of past tradition are sacrificed to improved technical planning; and the truth is subordinated to the appeal of the image [26]. From a world governed by principle we are moving to a world governed by mutual agreement, always under the supervision of big brother, the information processing machine [9, 22].

The predominance of the machine and its handmaiden, the human organization, is slowly changing the professional tasks of psychologists, psychiatrists and therapists. But because of what is known as cultural lag, the contemporary attitudes, laws, and social order are predominantly geared to the technological and scientific conditions of one to two generations ago. Therefore, modern ways may be opposed by the older generation, the conservatives, and those who have a vested interest in existing products and procedures [11]. The discrepancies resulting from rapid diffusion of new technical knowledge and the slow adjustment of people and social institutions to these ideas give rise to a variety of social conflicts. The inefficiency connected with the use of old methods to cope

with new problems creates conditions that professionals frequently are called upon to unravel.

The psychiatrist in the technological age

With the advent of the mass population, patient oriented medicine has receded into the background. The older approach characterized by an identified patient, an identified doctor, and an identified disease has given way to *probabilistic medicine* whereby the sick patient has been replaced by the problem population, the doctor's place has been taken by the interdisciplinary health team, and the focus upon diagnosis has been overshadowed by a statistical consideration of various health risks. The shift away from emergency medicine, with its emphasis upon diagnosis and lifesaving treatment, towards a plan of lifelong medical care and prevention of illness has been supported by legislation and insurance schemes with the result that in the Western civilization medical care is considered a human right for all.

Faced with far-reaching changes in the political arena, in the scientific laboratory, and in medical care procedures, the psychiatrist, the psychoanalyst, and the psychotherapist had to revise both their ways of studying human behavior and the approaches they used to influence disturbed behavior. Because the population explosion and the increasing number of people who avail themselves of psychiatric services limit drastically the number of cases that can be seen in traditional long-term therapy, the model of preventive medicine was introduced into the field of mental health [6]. The psychiatrist learned to focus not solely upon the patient but upon the total situation in which a behavioral disturbance occurs. By utilizing workers from allied professions, the therapist has added crisis intervention in the community, job or agency consultations, family discussions in the doctor's office, and group psychotherapy meetings to the approaches that are at his disposal [2].

The modern therapist's work takes place at two levels. On the *individual level* the psychiatrist managers states of disturbed behavior, helps his patient to accept the realities with which he has to cope, and guides him towards self realization and emotional maturity [31]. At the *group level*, the psychiatrist advocates the solution of human problems through social rather than psychological means. For this purpose the psychotherapist cooperates with organizations, institutions, the government, and

other groups, and reminds them that human needs take precendence over technological and economic considerations, thus introducing attitudes conducive to mental health. From a theoretical viewpoint, the psychiatrist has shifted his focus from individual to group, from psychopathology to social pathology, and from psychodynamics to social dynamics. From a practical point of view, his methods of intervention have veered away from the traditional one-to-one relation to multiperson interaction, and from treatment to prevention. To help people get along in a man-made, artificial, technical environment as members of vast social machineries and with an ever-decreasing degree of individual freedom is the task of a variety of new disciplines that range from social or comprehensive medicine to social and community psychiatry [32].

In the field of the health sciences the *subject matter* of the medical psychotherapist is disturbed behavior; his skill is therapeutic intervention; his principal tool is communication. The leverage a therapist possesses is largely due to his ability to increase or decrease tension. This is how it works: any individual compares the image he has gained of a certain event with the image created through the statements of others. If the two images coincide, tension decreases; if they do not coincide, tension increases. In order to reduce the tension, the individual either adapts his information to that of the others or he attempts to control people and situations in such a way that his own views will prevail.

Most individuals are particularly sensitive to the image they possess about themselves. The precarious balance between individual *identity* (image of self when considered alone) and group identity (image of self juxtaposed to image derived from statements of others) can be altered by influencing perception and awareness concerning the differences that exist between self and others. Perceived social differences can be increased or decreased through three fundamental processes: understanding, acknowledging, and agreeing. Understanding is based upon the availability of satisfactory explanations that will justify the differences. Acknowledgment refers to the response received following a message addressed to another person. Agreeing implies the isolation of a certain topic within the universe of discourse and the establishment of corresponding views or opinions, a necessary prerequisite for action. Understanding, acknowledging, and agreeing all are gratifying experiences in that they represent steps towards ultimate action, with its tension-reducing effects [31].

The modern therapist rarely treats a patient in isolation from his family or group. Therefore, once the therapist is called upon to assess,

advise, or intervene in interpersonal or social conflicts he first must decide whether the differences should be increased or decreased. If he believes that opinions and views can be brought closer together, he will use methods that are intended to *equalize information* [33]. Among these are:

1. Communication, which is achieved through exposure of people to similar persons and situations, resulting in equivalent experiences.
2. Communicative exchange, which is facilitated by social interaction and contributes to a leveling of information and behavior and to mutual understanding.
3. Interpretation, which leads to a sharing of explanations to justify existing differences.
4. Coercive action or threats which induce people to change their views.

If the therapist believes that the views or opinions held by people will not converge, he may attempt to disrupt the steady state that stabilizes the conflict. This he can achieve by increasing the differences between the participants, perhaps to the point where they will part company. *Asymmetry of information* can be increased through:

1. Solitude, by isolating one or more individuals from the group and exposing them to their own selves.
2. Exposure of one or more individuals to situations that the others do not participate in (schooling, demotion, promotion).
3. Culture change, by exposing one or more persons to new values (travel).
4. Unusual life experiences not shared by others (disease, accident, war).

If these procedures fail to reduce tension, or if a group situation is beyond reconstruction, four possible *consequences* have to be considered:

1. One or more members may adapt pathologically to the group, in disregard of their own needs.
2. One or more members of the group may rebel and attempt to change the task of the group or its rules by subversive means.
3. One or more members of the directorate may be replaced.
4. The group may be split.

After reorganization has taken place the therapist may introduce measures that will improve the communicative skills of the participants in the hope that mastery of communication will enable the members to reduce tension through equalization of information [31].

If most of the above methods serve to enhance the patient's or the group's adaptation, programming and organization aim at better *control.* Such programming has to be worked out first on paper. This is followed by trial in action; then proper corrections have to be made; and finally the participants have to master the program until its execution becomes automatic [38]. *Programming* of an individual or of a group centers around specific tasks. Each task requires:

1. Allotment of proper space (living quarters, office space, play field).
2. Allotment of sufficient time.
3. Proper timing in terms of coinciding with, preceding, or following other events.
4. Regulation of energy household (physical strength; alternation between rest and exercise, play and work; diet; work and vacation).
5. Allotment of proper funds (budgeting for the occasion; for the week, the month, the year).
6. Allotment of proper technical resources (transportation, tools).
7. Integration of requirements for space, time, timing, energy, funds, and resources into an over-all pattern.

Unfortunately, programming of individuals or small groups may fail if not matched to the large-scale social organization in which the interaction takes place [25]. The features of the *organization* that have to be considered are:

1. The characteristics of the network, consisting of input, central functions, output, and feedback devices.
2. Criteria of membership in the organization.
3. Identification of rules and provisions for violation of rules.
4. Specification of positions and permissible role modifications.
5. Characteristics of the maintenance processes of the organization.
6. Description of the values and ideals to which the organization subscribes.
7. Description of the rewards that the organization has to give.

The rules of the small group have in some ways to be coordinated with the laws of society at large, and the roles must be familiar to members of other groups. The task of the therapist and manager is to a large measure related to ironing out the differences between individual and small group and between small group and society [3]. The energy and force required to maintain deviance against societal opposition are so overwhelming that it rarely succeeds. Particularly in recent times, where large-scale organizations rely on office automation and computers, the basic rules of operation are difficult to change. For these reasons, the psychiatrist must be thoroughly familiar with the values, social structure, and technological organization of society if he is to help individuals and groups.

Computer aids for the therapist

In modern enterprises, be they industry, government, the military, or the university, the computer is a silent participant in the patient's life. Data about him and the doctor, about his illnesses and college grades, about his finances and political beliefs, are duly recorded and stored. Before long the psychiatrist himself will use the computer in the interaction with his patients. The computerization of information gives every statement two faces: the official version which is entered on the IBM card or tape, and the private version which remains anonymous [15]. This dual aspect of communication will change our lives profoundly, and a word about the computer may be in place.

If the first million years of man's technological evolution were devoted to the extension of his motor system, the last four hundred years have added extensions of his sensory system. Only within this century have machines been made to amplify his central functions, and by now the computer has been accepted as man's auxiliary brain [14]. The *computer* works on a binary system, and it can compute at a rate that is easily a thousand times faster than the human brain; its components are arranged in series, but all of them have to be in working order if it is to function properly. The brain, in contrast, has about a thousand times more nerve cells than the largest computer, occupies considerably less space, and works on a multiple input system that can process different kinds of information simultaneously. While computers can attend to one task at a time accurately and speedily, the brain can pursue several things simultane-

ously but with less acuracy. Loss of cells does not appreciably influence the functioning of the brain as a whole, a feature that is helpful in the survival of the individual [10].

Computers lend themselves superbly for *information storage and retrieval* [20]. Journals, books, and possibly personal notes in the future will be stored electronically. Access to the electronic memory is gained through dialling from one's desk, reaching the desired page in the micro-library in a matter of seconds. Computers also are helpful in collating data, compiling statistics, calculating, making medical diagnoses, or assessing personality [21]. These features simply extend the human range of memory, increase the speed of scanning and computation, and sharpen logic and accuracy [24].

Most relevant for therapists are teaching and *therapy machines*. A computer can present questions or pictures to a student, who in turn has to give a response, either through typewriter, through manipulation of dials, or through pointing with a magnetic pencil. If the response is acceptable, the computer proceeds to the next task; if it is not, the computer may give the student more training on the spot. Such computerized teaching programs can be used with a variety of psychiatric patients such as the mentally retarded, the brain diseased, or the emotionally slow learner. The computer has infinitely more patience than the human being to repeat tasks at the rate the patient chooses. As a teaching machine it has the advantage of being at the disposal of the student whenever he chooses [8].

Scientists at the Massachusetts Institute of Technology, the University of Michigan, and the University of California have tackled an even more fascinating task – the development of a program for *man-machine interaction*. Without entering into further details, it may suffice to say that first a suitable language had to be developed [50] to encode the program. Then this had to be adapted to psychiatric interviews [46]. Thereafter a program could be written that simulates the behavior of a patient and a second program that simulates the behavior of a therapist [47]. When one reads the transcript of a simulated patient-actual doctor interview, it resembles the protocol of a medical student's or first-year resident's interview with a patient. The simulated doctor-actual patient interaction is even better. The crowning glory of computer simulation, of course, is the conversation between two computers, one simulating the patient and the other simulating the doctor. The conclusions one can draw from this experiment I shall leave implicit.

The future of psychotherapy

Psychotherapy has come under attack from many quarters: it has been accused of not being a science; of not even being a discipline; of not producing practical results evident in morbidity and mortality statistics; of being suitable only for the few and the rich; and of not being adapted to the modern computer age. If psychotherapy is not a science, if it is not an art, if it does not possess specific treatment methods, and if it does not have a generally accepted theoretical framework, what is left of the field? In its present form, little; but in a new form, much. More and more the public is demanding that professionals be concerned with problems of living. This, however, implies that we have to stop borrowing concepts and methods from other disciplines. If we imitate large-scale social approaches, we have to concede that industry, government, and the military do better. If we pride ourselves in developing scientific models, it is obvious that scientists or mathematicians are superior in this pursuit. If we equate the human being with a machine, then we must lose out to the engineers. But if inner experience, human development, and social interaction stand at the core of our endeavors and if we become the spokesmen for '*the individual*' in a world in which institutions, organizational machineries, and technology depersonalize living, we have sharpened a subject matter that is definable. If we emphasize 'the personal approach' and specialize in 'solving human problems by human means', we have found a worthwhile task for therapists and psychoanalysts [34].

In accepting the redefinition of the goals of psychotherapeutically oriented professionals we must also revise our educational procedures. No longer must we educate people solely in the closed system theories of psychoanalysis [23], but we have to give students an idea of man as a whole: his behavioral requirements, his social needs, his interdependence with the environment. The subject matter cannot be limited to psychic processes but must include the transactions with the environment. The 'living individual' is a topic currently not taught in any academic school of medicine or in any department of psychology, sociology, or anthropology; nor is this topic transacted in the psychoanalytic institutes. The therapist's *education,* therefore, has to be broadened to include some of the subject matter of the social and biological sciences, while his practical training should familiarize him with the approaches of the managerial disciplines that attempt to influence behavior of people in groups [30].

In recent years a remarkable convergence has occurred among fields that share in common the tendency to steer, organize, or change human behavior. Under the impact of diversified disciplines such as psychoanalysis, group dynamics, organization, communication engineering, and management, a science of social operations is slowly emerging. In contrast to the univariate approach of the physical sciences, the modern multivariate approach [7] to phenomena of living consists of pattern identification, pattern analysis, establishment of probabilities, and action or communication based on incomplete information. The dissection of observation of human behavior must include three positions of the scientific observer: the inside view – psychology, psychopathology, and psychodynamics; the outside view – anthropology and sociology; and the component parts – biological and medical science. The remedial operations would simultaneously occur at three levels. With the individual we call it treatment, with the group we refer to it as management, and with large-scale organizations we call it reorganization.

The blueprint for the larger field of mental health then would look as follows: *Biological psychiatry,* ranging from molecular biology to experimental neurosurgery, constitutes the division of the hard sciences made up of molecular biology and physiology. *Social psychiatry,* ranging from medical sociology and anthropology to family interaction, is the division of the operational sciences, including such approaches as public health, community psychiatry, hospital administration, group management, and social organization. *Psychological psychiatry,* finally, applies to whatever science, management, religion and the humanities have to offer to individual development. Psychological psychiatry aims at becoming the spokesman for the individual vis-à-vis society; and with its therapeutic tools it attempts to help individuals grow and mature, depending upon their circumstances, native endowment, and past experience. Not only the unconscious but the whole field of perception and cognition; not only word associations but the whole field of expression and action; not only the therapist but the whole range of the patient's relations have to become the concern of the modern psychotherapist. Only if we put the person into the center of our considerations can we oppose the trend of molding man in the image of the machine and can we prevent shaping the environment according to principles that first and above all accommodate inanimate things.

Summary

The 'person orientation' that dominated the Western world for over two thousand years gave rise to the psychological view of human affairs. However, with the advent of the atomic age and the use of computers as auxiliary brains individualism began to decline. As man and machine became somewhat interchangeable and automata replaced people in a variety of tasks, a 'system orientation' developed in which people, machines, and the environment are considered as a unit.

These technological, economic, and social changes forced the psychotherapist to shift his cognitive emphasis from individual to group, from psychopathology to social pathology, and from psychodynamics to social dynamics. Consequently, his methods of intervention have shifted from one-to-one relations to multiperson interactions and from treatment to prevention. As a result, the psychotherapist is cast into a new role and he is fast becoming a change agent for smaller social systems. Within such a framework, of course, theory, practice, and education of the therapist will have to undergo significant changes.

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Author's address: J. RUESCH, M. D., Dept. of Psychiatry, University of California School of Medicine, *San Francisco, Cal. 94122* (USA).

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Psychotherapy in the Twenty-first Century
An Exploration of the Basic Determinants and Trends of Psychotherapy in our Future Society

ST. LESSE and W. WOLF, New York

While the world is always in a state of revolution, the rate of change that has occurred technologically, socioeconomically, sociopolitically and sociophilosophically since the end of World War II has accelerated to a degree that has never before been experienced in history. In this paper we will attempt to characterize the world of tomorrow, focussing upon three basic elements and drawing upon certain basic assumptions and deductions that seem to emerge with Western civilization as it is likely to be in the coming generations. These three elements are:

1. socioeconomic and sociopolitical changes,
2. overpopulation with limitation of available space,
3. automation.

Based upon projected trends we will attempt to outline the nature of man's illnesses and his expectations with regard to medical treatment.

1. Socioeconomic and sociopolitical forces

There appears to be little doubt that our society will become increasingly group oriented and more highly organized. The force of the mass increase in population, which will be discussed later, is likely to accelerate the process. As our society becomes more complex, social organizations will not only tend to become unified, but also more specialized. Man will incline largely to group goals, while expectations emphasizing personal

preferences will be much less appreciated. Indeed, great individual expectations are likely to be looked upon as odd, reactionary and anti-group. Unanimity of thinking would be seen as the normal pattern.

In this now, tightly organized society, individual competition must also be greatly reduced. The individual, rather then being preoccupied with his personal self, will find it necessary to change his orientation to fit himself in as part of an integrated group in order to be accepted by his society, indeed to survive. He very likely will strive to become an integral part, a dependent member of the interdependent structure. In turn, he will, as a matter of course, perform specific functions and tasks. In this process, certain of his capacities, functions and even his body structure will change, with some areas undergoing atrophy and others hypertrophy.

A man raised in an organized world, such as has been projected above, is likely to develop expectations different from those considered commonplace today. He will have been raised to subordinate himself to the purposes of the group, as a matter of course; he will not consider himself as an important factor for his own sake, but important only as far as he is part and parcel of a successful group structure. As such, he will hardly expect individually oriented medical care. Rather, he will anticipate being treated on a group oriented basis, with therapy being directed, in the main, to returning him to the group with optimal speed. He is likely to experience illness as being detached from the group and health as being well integrated into the group. One of his great concerns may well be the threat of physical and psychologic separation from the group. An individualist will be a maverick with expressions of individualism being considered as an ailment and, as a corollary, rejection by the group may lead to illness.

2. Population changes and limitations of available space

Despite efforts to retard the population increase, it is estimated that the world population by the year 2000 will be six billion people, or approximately three billion more than now. This means that in less than 35 years, the number of living persons will have doubled.

One of the crucial factors that will shape our future society will evolve around the fact that land space available for living and working is fixed and limited. This, together with the accelerating trend toward urbanization, will make horizontal expansion difficult, if not impossible, with the result that expansion will have to be vertically upward. Organized meg-

alopolises will be formed. For example, one such megalopolis in the United States will extend from New England to Washington and contain 80 million people.

Population expansion and urbanization will necessitate increased structuralization of society, for when individuals are integrated into an organized group, the space necessary to permit effective functioning is reduced. Since the group ego will predominate, increased organization of our society is likely to be requested and readily accepted. While careful specialization will be stressed, it will probably be in a context of indivisible relationships.

3. Automation

A great misunderstanding exists with respect to the concept of automation. All too often it is confused with very sophisticated mechanization. Indeed, the two are often used interchangeably. Actually the most sophisticated mechanical system, no matter how great the number of its components, is an open system that cannot operate unless the controlled loop is closed by a human being. In contrast, a fully automated system is closed, the human component being supplanted by a computing machine.

The new world of the closed, automated system will necessitate a radical change in political, technologic and social thinking. During the agricultural and the later industrial revolutions, man developed increasingly complex tools and systems that extended his sense perception and increased his skill and strength. In these systems, however, man was the inevitable factor that could direct and guide these tools. Hence, he was the unavoidable link in providing for his own well-being.

The cybercultural revolution is changing all this. It differs radically from previous innovations, because now man has devices that will largely supplant his labor and certain activities of his mind. As a result he will have to find new tasks to occupy his time, since he will no longer find it necessary to use it for toiling in the fields or manufacturing his goods. In the age of cyberculture, enormous segments of the population will live in leisure. Only a few will 'labor' in the sense of drudgery.

Cyberneticists have written that in the new development of cyberculture man must learn to live in leisure and abundance [1]. However, leisure must not be confused with idleness nor abundance with waste. Although computing machines and automation are in their infancy, they have already made far reaching and indelible changes in our current world.

Before long our industrial capacity will be of a magnitude that will dwarf the most generous predictions. At the same time fewer and fewer men will be required to produce more and more. Heretofore, unemployment as the result of automation was considered as affecting principally unskilled labor; automation also will replace those whom we now consider to be highly skilled technicians. This will have the effect of 'equalizing' men, so that automation in itself will have a profound impact on both the economic and philosophic aspects of this new revolution.

We cannot stress too strongly that automation, social and economic change and the population increase must be viewed as an indivisible, interreacting group of forces. It would lead to serious error, if we were to consider the progress of automation without simultaneously taking into account the other factors.

The nature of illness in the future

All indications point to the likelihood that we will encounter relatively few instances of so-called 'acute conditions', mostly infectious diseases, with their complications and sequelae, of which we have had such a plethora until recently. They will be rare not only because we will be able to treat them effectively with broad-spectrum therapies, but also because the very transmission of infection will be greatly diminished. Preventive medical techniques will immunize most persons from the sources of infection. The problem of resistent organisms will probably have been conquered.

The principal acute processes that will be encountered are likely to be the results of traumata, hemorrhage, burns, radiation and the like. In addition, we will encounter acute phases or exacerbations of chronic illnesses, which will be managed primarily by preventive measures or by treating the more chronic underlying matrix. Acute processes will also include acute psychic problems, some representing exacerbations of congenital defects and some that are precipitated by various psychosocial traumata.

Chronic ailments will be the ones that will constitute the bulk of medical practice, partly due to the fact that life expectancy will continue to increase. There will be problems related to genetic mutations, many secondary to increased radiation fallout. There will be the effects of toxic materials ingested over a prolonged period of time in the form of preservatives, air pollution, artificial treatment of drinking water and the like.

Increasingly crowded urban conditions coupled with a possible downgrading of the importance of the family as the basic social unit may be a source of considerable emotional stress for some time to come. In addition, of course, entirely new causes and types of somato-psycho-social problems are likely to arise.

The sources of psychosocial stresses very likely will differ considerably from those of today. As indicated, they will probably be determined in great measure by the fact that the group ego will supersede the individual ego in importance. Stresses are also likely to result from a de-emphasizing of the family as the primary teacher of the child. Moreover, if the parents no longer will be the prime sources of early instruction, many of our concepts of psychodynamic development will require considerable revision. Then too, the child's relationships with other persons in the community are likely to be markedly different from those which we consider par for today.

The most significant psychosocial difficulties will most likely be traceable to group maladaptation and rejection by the group. Thus, quite new concepts of human relationships leading to other psychosocial stresses are likely to show up. Preoccupation with romantic love may well become diluted and many interactions between men and women may change considerably. Stress on sexual gratification, which is so intimately incorporated into our present culture, may play a lesser role as a source of psychic disturbance, so that our future society might be far less sexualized.

Psychotherapy

The role of the psychotherapist, as we currently understand it, is likely to be altered dramatically. Diagnoses probably will be made by means of a closed, automated system in which the psychiatrist or psychologist will be replaced by a programed computing machine that, by means of 'computest language', will take most definitive histories. These histories will be coupled with physiologic and biochemical data that will be obtained simultaneously. While this concept may seem outlandish to some readers, we would like to point out that currently computers are being programed to take histories, to act as therapists, to act as patients, and to make differential diagnoses.

It is not unlikely that many of the psychoses, including the schizophrenias, manic-depressive psychoses, many depressive syndromes and

some heredito-congenital processes will be managed primarily through biochemical means either in the form of replacement therapy or by eliminating a biochemical excess.

The theories and techniques of psychotherapy will be changed or modified in a manner that will make them compatible to the needs of the day. New techniques will be dictated by the shift in the prime sources of psychic stress from real or apparent intrafamilial deprivation to maladaptation to a rapidly changing, increasingly organized, and ever more crowded and automated society. Most men, as always, will be able to adapt to the altered scene. The greatest difficulties are likely to arise during the last decade of this century and the first few decades of the next century, for while the rate of change may not be as great during these periods as it will be later in the twenty-first century, the qualitative shifts will be most pronounced.

Psychotherapy will probably find its most important role as a prophylactic tool. Psychotherapists are likely to find their major functions as 'psychosociologists', serving as analysts and advisors to government agencies in an attempt to build compensatory factors into the politic-economic-technologic system in order to make it optimally compatible to man and *vice versa* [3].

For example, in order to help our society adjust to the forces of automation and its attendant social changes, an entirely new orientation to education is in order. No longer will education be directed mainly toward the goal of enabling the individual to earn a livelihood, for this will be produced by machines and provided to all, as a matter of course, by the society. Psychotherapists will likely be involved in the formulation of this new educational framework. Psychotherapists, as psychosociologists, will also be preoccupied with the question as to exactly what the sources of pride and pleasure will be for the man of the future, when labor will no longer be the prime motivation for his existence. There will also be a basic concern in the not too distant future with the development of man's inner resouces, both within himself and within his group constellation. These problems will necessitate penetrating awareness of the interrelationship between man's group ego and man's individual ego in an era when the individual ego will be deprecated as being unworthy and as being synonymous with selfishness, while the group ego will be extolled.

As noted before, the techniques of psychotherapy will be adapted to the needs of the culture. Since patients are likely to be group oriented in a way and to a degree that would be alien to our current society, psycho-

therapy will be aimed at reinforcing the group ego, while at the same time subduing the 'threat' of the demands of the individual ego. This will necessitate a type of group therapy, since a one-to-one patient-psychotherapist relationship would probably nourish the patient's individual ego [2].

We believe that it is not unlikely that a type of group therapy based upon learning theory and conducted by programed, computerized systems may be one of the main psychotherapeutic techniques. Its main function will be to correct the patient's maladaptation to the group. The therapeutic process will deal mostly with conscious factors. However, aspects of the 'group unconscious' will also be a focus of investigation and reinforcement. New conceptualizations of psychodynamics will evolve which will view individual psychodynamics in an indivisible relationship with sociodynamics, with the latter being weighed as the more important process and individual psychodynamics viewed as an extension of sociodynamics.

We believe it is not unlikely that therapy will include the use of somatopsychic relaxation exercises with patients attaining states of psychic detachment akin to that described by the Zen Buddhists as Satori. Beginning with this relaxed state in which the initial level of anxiety is low, the group therapy 'social reconditioning' processes will proceed with repeated reaffirmations of the need by the patient to adapt to the group and reaffirmations of the dominance of the group ego over the individual ego.

Individual psychotherapy may be preserved and utilized in combination with group therapy. It would be applied to the elite class who will most likely be the programers of the automated systems. These programers will have more highly developed individual ego structures, this being the prime source of their psychic difficulties in a society that will depreciate the individual. It is from these discontented, conflict ridden programers that future progress is likely to come with ideas generated by frustration.

We appreciate that the outline presented as to the likely structure of psychotherapy in the twenty-first century is very sparse. Future papers will elaborate upon or modify that which is given here. Let us emphasize, however, that our conceptualizations are not presented with any sense of dogmatic certainty; rather, they represent tentative probings that will be subject to modification, revision, or even radical alterations when dictated by the events in the emerging future.

Summary

The current socio-technologic revolution is causing changes at a rate that has never before been experienced in history. We have attempted to characterize the world of tomorrow, as it is likely to be by focussing on three basic elements. These are:

1. socio-economic and socio-political changes,
2. over-population with limitation of available space, and
3. automation.

Based upon projected trends, we have attempted to outline the nature of man's illness and his expectations with regard to medical and psychologic treatment.

The causes and treatment of psychologic illnesses in the future are likely to differ dramatically from those which we understand today. Some suggestions as to the character of the future treatment of psychologic illness is outlined.

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Authors' addresses: ST. LESSE, M. D., Med. Sc. D., 15 West 81st Street, *New York, N. Y. 10024* and W. WOLF, M. D., Ph. D., 40 W. 59th Street, *New York City, N. Y. 10019* (USA).

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Prevention: The Major Task of Military Psychiatry

D. McK. Rioch

Walter Reed Army Institute of Research,
Division of Neuropsychiatry, Washington, D. C.
(Director: D. Mck. Rioch, M. D.)

Although much of psychiatric theory is formulated in terms of the so-called individual psyche or personality, it has long been recognized by child psychiatrists that treating the family – and thus controlling the responses of the social environment to the child's behavior – is a crucial feature of the treatment strategy.

In several respects the principles underlying the various therapeutic manoeuvers found to be useful in the treatment of the child-family organization are analogous to those which have been formulated in the course of the development of military psychiatry in the United States during and since World War I. This becomes more evident if one regards the family or the military unit, with which the psychiatrist deals, as an organism in interaction with its environment [Rice, 18]. In this sense, families and military units are open systems, each with a primary task on the accomplishment of which the responses of the environment depend. These responses provide the material, social and other support necessary for the survival of the organism. The family and the military unit may also have secondary tasks and, in the course of time, the primary task may well change. As long as such factors, as well as the constraints culturally and otherwise imposed on the functions of the organism, are made *explicit* they can be communicated, or shared in a manner to facilitate the solution of problems. *Covert* tasks or objectives, however, cannot be clearly communicated, i. e., shared, and can wreck organization with the result that the family or the military unit may well produce so-called *ill* members. Most of these are not 'ill' in the sense of having 'a disease' which makes them 'abnormal' and which needs to be 'cured'. Rather, these deviant members have learned an essentially normal adjustment to a social environ-

ment distorted by incompatible objectives and unreliable signals and consequences.

It should be noted that in most communities all preventive medicine, to be effective, requires laws and law-enforcement agencies as, for example, in the control of water, sewage disposal, food and drugs. One might consider compulsory education and the legal control of delinquency in minors by the use of rehabilitative institutions, as equivalent social controls in the field of community preventive psychiatry.

Military psychiatry offers a remarkable opportunity for study of the principles of preventive psychiatry. It provides a clearly defined community, both structurally – in its membership and hierarchical form – and functionally – in the sense that all units and members of units have a common goal, though their technical contributions to its attainment differ. Whereas the civilian psychiatrist has to decide between several possible objectives of therapy which may or may not be mutually compatible – such as, the patient's comfort, his performance, his family's or his employer's satisfaction, etc. – the military psychiatrist has the same task as all other medical officers, namely, conserving the strength of the Army. The psychiatrist's attention, thus, is directed to the soldier's performance. The performance of the average soldier is well-known in all military units, so that inadequate performance can be recognized and corrective measures instituted promptly. Further, the adequate performance of every man and of every unit in the hierarchical structure is also part of the responsibility of each unit as a whole and of its commanders. The psychiatrist, as a professional officer, consults with command on problems in his area of competence. He thus has the opportunity for testing and improving preventive psychiatric operations which involve the functions of the group. Consequently, it is not surprising that military psychiatry in the United States has developed as the prototype of community, preventive psychiatry [HAUSMAN and ROOCH, 14].

The historical evolution of modern military psychiatry cannot be reviewed here in detail, but a few comments on particular features may prove useful. The organization of the psychiatric service in combat was first planned by Colonel THOMAS W. SALMON and Colonel PEARCE BAILEY in World War I on the basis of their studies of psychiatric problems and treatment in the British and French armies before the American Expeditionary Forces entered the war [20]. They established the use of Division Psychiatrists for prompt triage and brief treatment in the divisions (i. e., in the periphery), with evacuation of recalcitrant cases to special Neuro-

psychiatric Hospitals not far to the rear. The whole was under the direction of the Consultant in Neuropsychiatry to the Theater Surgeon. The therapeutic procedures emphasized the expectation that the casualties would recover and return to duty. This expectation seems to have been a part of the general social attitude of the period, which did not differentiate between personal and group objectives. The military objective was clear and was strongly supported by the general population. Both professional and lay groups seemed to assume that psychiatric casualties were either due to organic trauma – called 'shell-shock' – or represented a moral problem. Colonel SALMON and other American psychiatrists recognized the functional nature of the psychiatric symptoms, but the general expectant pressure for recovery and return to duty remained as a positive attitude and without moral approbrium.

By the time of World War II, the lessons learned in World War I seem to have been forgotten in the United States [STRECKER, 21] and no preparations for separate management and treatment of psychiatric casualties were made at the time of the American landings in Africa [DRAYER, 7]. Psychiatric casualties were the responsibility of the Consultant in Medicine to the Surgeon, African Theater. Early, they were evacuated to the rear and the psychiatrists at first attempted to treat them with individual psychotherapy as cases of 'traumatic neurosis'. The return to duty rate was negligible and the loss of manpower reached dangerous proportions [COOKE, 6]. The principles of combat psychiatry of World War I were relearned under combat conditions and eventually (in the Italian Campaign) were reinstated. The results were dramatic. Not only did the large majority of psychiatric casualties recover and return to duty, but the rate of incidence was greatly reduced. These results established the preventive aspects of combat psychiatry as well as its therapeutic aspects and provided the basis for extending the principles to the psychiatric service in other situations.

In retrospect, the terms *proximity, immediacy* and *expectancy* have been used to epitomize the principles of military preventive psychiatry. They refer to: 1. treatment in the periphery, close to the casualty's unit; 2. initiation of treatment as early as is feasible, before the casualty's alienation from his group of allegiance becomes organized; and 3. conveying the message of expecting recovery and return to duty, recognizing the personal implications, but also recognizing the needs of the unit.

In the course of the Italian Campaign and later in the Korean War, a variety of clinical studies were conducted testing the use of different thera-

peutic measures and investigating the role of the psychiatrist and his assistants. Colonel ALBERT J. GLASS, MC (Retired) was largely responsible for the continued development of this field and much of the work was summarized in two symposia [5, 22]. Later, Colonel GLASS investigated the application of the principles derived from combat psychiatry to the work of the Mental Hygiene Consultation Division in training centers and other military installations in the United States [11]. He has also described the application of these principles to the management and treatment of mass casualties in disasters [9].

Longitudinal studies of the effectiveness of military psychiatry during combat were carried out by GLASS [8] in Italy, and HARRIS *et al.* [13a, b] in Korea. Both studies showed that approximately 2/3 of the men treated and returned to duty from Division level performed in an average to superior manner. In Korea another 20 % performed sufficiently well to remain with their units, and only some 10–15 % were returned to the psychiatrist. Possibly of greater significance was the fact that when Division Psychiatrists visited rifle companies at the front, men they had treated and returned to duty expressed no resentment. Not infrequently, however, these men thanked the psychiatrist for having helped them demonstrate that they were adequate persons and able to perform the duties expected of them. As the methods of military preventive psychiatry have been further improved and extended, their effectiveness has been increased, as shown in several general and statistical reports on psychiatry in the Army [GLASS *et al.*, 11; PETERSON, 17; TIFFANY and ALLERTON, 23].

Modern military psychiatry has been developed on an empirical basis, at first in response to necessity and later because of its effectiveness. It is essentially a behavioral operational system insofar as published theory is concerned. As pointed out in an excellent descriptive summary by BUSHARD [3], the question of the cause of the breakdown in adequacy of performance is not raised, but attention is directed to the environmental contingencies (chiefly, social responses) which reinforce the 'identification' of the man with his unit. Clarification of the factors involved or, at times, their appropriate manipulation can be used to reduce those interactions which increase the man's alienation or which reinforce tendencies to identify with some 'ill', 'delinquent' or other subgroup, increasingly separated from his primary group of allegiance. The symptoms, including the verbal, gestural and other behavior usually represent one or another of some half-dozen syndromes typical in the army at the particular time and place [GLASS, 10]. It is unnecessary and usually deleterious for the

psychiatrist to explore possible 'causes' of the disturbance in any postulated construct, such as, in the 'psyche', the 'personality' or the 'social-field'. Rather, it is highly important for him to know the probable course of the syndrome so that he can listen to the man with understanding as the process of reorganization of the latter's relations with his unit develops. The psychiatrist, thus, needs to know the unit from which the man comes, its tasks, its commanders, the pressures it is under, and so forth. This knowledge is necessary to help clarify factors about which the casualty is confused. It also is needed for consultation with the officers and for the eventual necessary decision on disposition, whether return to full duty, limited duty or evacuation for continued treatment.

Preventive psychiatry, as all preventive medicine, requires that the major part of the work be performed by sub-professional, technical personnel under the direction of a limited number of professionals. The model psychiatric team in the Mental Hygiene Consultation Division in military camps in the USA consists of a psychiatrist in command, a social work officer and a psychologist with several enlisted social work or neuropsychiatric specialists. (Specialists are technically trained men and have the status of non-commissioned officers, but their authority is limited to their areas of technical training.) The composition and size of the team vary under different circumstances, but the principles of operation are relatively constant. It is spatially separated from the hospital and preferably situated close to the troop area in the camp. The enlisted technicians are assigned to battalions in the camp and make the initial contact with referrals in the Company areas. They also get additional data on the problems from the officers of the man's unit. Experienced specialists may handle the simpler problems themselves in the Company area, but send most referrals to the Mental Hygiene Consultation unit. The professional officers supervise this work and give the specialists further on-the-job training. They also treat the more difficult cases and consult with line commanders and their staffs on personnel problems in their units and on men who have received treatment and returned to duty. All referrals involving legal problems and all seriously disturbed men are seen by the psychiatrist, who is also responsible for the final disposition of cases.

The operations of the Division Psychiatrist in Divisions in the field are similar [MILLER, 16] excepting during combat. In combat the enlisted specialists are primarily involved in maintaining the psychiatric unit where casualties under treatment or for observation are held, in uniform and under appropriate military discipline. The specialists take the routine

histories and have the day-to-day management of the casualties, reporting to the psychiatrist on their course. The psychiatrist briefly interviews casualties as seems indicated, maintaining attention to clarifying the precipitating events and the process of recovery. This includes empathically accepting the casualty's needs for emotional expression as he reorients himself in the situation.

As in general preventive medicine, one can distinguish three levels of prevention [GLASS *et al.*, 11; CAPLAN, 4]. *Primary prevention* is the attempt to modify the environment in order to reduce factors predisposing to breakdown and to strengthen factors supportive of the unit and its members. *Secondary prevention* refers to early recognition of symptoms and either treatment in the field or evacuation out of the unit, in order to correct maladaptive processes or to interrupt them before they become more disruptive. *Tertiary prevention* involves psychiatric treatment of a patient, usually in a hospital, to reduce his disability, to relieve his unit of the problem he poses and to accomplish this in a manner to assure all units that they are considered worthy of as good medical support as is available. Recovery of the ability to perform full or limited duty may occur at any level, though with a decreasing rate. The basic emphasis throughout is respect and consideration for the soldier expressed by attempting to improve his 'commitment' to his unit and the unit's 'concurrence' in his performance, to use the terms introduced by BUSHARD [3] in his excellent summary of primary and secondary prevention [cf. also HARE, 12]. ARTISS [1, 2] has presented the application of the principle in tertiary prevention in the military hospital in detail.

The reciprocal commitment-concurrence relationship requires adequately stable group organization, itself dependent on clear communication and a planning and decision-making authority. It is not feasible here to discuss organization as a function, its boundaries and its relationship to the group task and objectives [RIOCH, 19]. The formulation of authority is difficult, though it is evident that it is bestowed by the group or must be arbitrarily imposed by some extra-group agency. Clarity of communication – or the sharing of information [15] – requires consistent messages, avoiding discrepancies, anachronisms and unnecessary redundancy, whether the messages are transmitted through words, acts, gestures or their implications. Thus, the location, the uses of personnel, the management of referrals and casualties, the simplicity of therapy, the final disposal (by the psychiatrist's command) and other features of the physical organization and the therapeutic procedures of military psychiatry

have been developed so as to give a consistent message of expectancy of recovery and return to duty. An interesting example of the problem of communication was described to the present writer by Colonel GLASS while discussing his work with the Military Police on psychiatric screening of disciplinary offenders sentenced to the stockade (equivalent to a local jail for men convicted of relatively minor offenses). Colonel GLASS found that the policeman would promptly reject the concept of the offender as a 'mentally ill' person, answereing, 'I know what he's going to say next and what he's going to do. There's nothing wrong with *his* head'. However, characterizing the offender as 'weak and incompetent; a man who could not keep a job even in civilian life' was readily accepted and used. The work done by screening resulted in separating recidivists rapidly from the army before the repetitive cycle of 'tough defiance of rules and restraint' – 'apprehension, conviction and punishment' led to offenses with long sentences in the Disciplinary Barracks (penitentiary) and eventual dishonorable discharge. The results of interrupting this cycle early by identifying and separating recidivists from the army at the first stockade sentence led to a sharp drop in the population of the Disciplinary Barracks [GLASS *et al.*, 11] and to increased rehabilitation of young, immature offenders (who were deprived of the concurrence they had received in reciprocity with the recidivists). It would appear that since the police do not have psychiatric training, the term 'mental illness' implies that either they should change their methods or surrender their proprietary rights to manage the culprits to the psychiatrists. In contrast, in our culture the police has two roles, apprehending and punishing the bad and defiant, but aiding and directing the weak. Applying the designation of 'weak and incapable' shifts the policeman's role and provides him with a program of action he can carry out effectively. Other examples might be given, but this may suffice for emphasizing the importance for the psychiatrist to know the community, the implications of what he says, and the inferences likely to be drawn from his messages.

Summary

Certain aspects of the development of military psychiatry since its establishment as a medical specialty in World War I are briefly described. The organization of the military unit as well as its primary task, especially under combat conditions, favor a preventive approach, directed toward

the needs of the unit and utilizing the unit's supportive and therapeutic potentials. Methods based on the principles of primary, secondary, and tertiary prevention have been developed and found applicable over a wide range of conditions, as in other areas of public health medicine.

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Author's address: D. RIOCH, M. D., Walter Reed Army Medical Center, *Washington, D. C. 20012* (USA).

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An Ego-analytic Approach to Administration

(The Application of Psychotherapeutic Principles in the Organization and Development of Child Guidance for U. S. Air Forces in Europe)

J. Kuten

Department of Psychiatry, Tufts Medical School, Boston, Mass.

Although we do not like to admit it, much of what we do and create and build is of a random nature. Much of what we call organization remains skeletal, a framework and a rationale which time hopefully honors as tradition. In retrospect, when an organization has advanced from an infant idea to grown-up function it is often difficult to identify the early foundations now buried in the details and complexities of its every day life. These details may even assume a life of their own, hallowed by the explanation, 'Why we've always done it that way'. As the US Air Forces Europe (USAFE) Child Guidance Center enters its third year of life (a critical time in the development of the normal human infant), we have an opportunity to dissect through the flesh of the details to the integrating concepts that, if substantial and successful, have given the growing structure the basis of its solidity and weight.

A little history is in order at this point. Our clinical context is unique in that it is a Child Guidance Center functioning within the military community with fulltime personnel of the traditional Holy Three Professions, plus a Speech Pathologist-Audiologist. The Center is responsible for evaluation and disposition of children of Air Force families in Europe suffering intellectual, emotional or speech and hearing disorders.

The forerunner of the present Center began in 1962 with the use of local base welfare funds of the 7101st Wing to hire, part-time, a social worker and psychologist. These two supplemented the military psychiatric staff of the USAF Hospital Wiesbaden and relieved the pressure on military professionals to see children with problems in addition to their normal responsibilities for care of adult members of the community.

Later, as the news of available help spread to other bases and pressure for extension of care increased again, a committee chaired by General JOHN K. CULLEN, then command Surgeon, recommended the development of the present Center staff of six professionals, one child psychiatrist, two psychologists, two social workers, and one speech pathologist. The primary responsibility for bearing the cost of these salaries and expenses directly related to staff (about $ 69,000 annually) was accepted by the Air Force Aid Society. In addition, some of the Center's needs for support were to be met by the hospital itself. Responsibility for professional supervision was given the hospital. The Center's physical location within the hospital and the selection of a military child psychiatrist as Director was intended to facilitate the essential communication between our staff and the more established divisions of military medical service.

From its inception the Center has had to deal with problems inherent to its unique situation as well as problems common to all beginning organizations. For the sake of understanding, we can make an arbitrary division of problem areas into three: the first of these has to do with the scope of our responsibilities and factors directly related to location. The geographic vastness of the area which we serve meant that the conventional concepts learned from civilian child guidance practice within a limited area had to be modified. The fact of the location in Europe provides in itself additional unusual sources of stress upon the military family, indeed upon the total military community. This consideration could not be neglected. In fact, it provides the background for much of this discussion. The second problem area is the quality of the relationship of the Center to the community it serves. As will be described, this is complicated by the fact of the Center being the first of its kind within the Air Force social structure. Lastly, the Staff of the Center and the problems of administrative support of their creative functioning must be considered.

The stress of moving from one culture to another has been noted by many observers with professional scientific interest and documented by artists attempting to define the human condition. We comfortably use the jargon 'culture shock' to describe what happens to people who make such moves. Unfortunately, the giving of a name has way of granting 'magical' but spurious control over a situation, inhibiting further investigation. When military personnel come to Europe they leave behind institutions and people, geography that is familiar, and physical structures that are comfortable, as well as language and customs that are understandable and meaningful. Any one of these losses may prove disruptive to an individual's ego-in-

tegrity and certainly all of these losses provide a stress upon one's sense of identity. ERIKSON [1963] maintains that 'the sense of identity provides the ability to experience one's self as something that has continuity and sameness, and to act accordingly'. This sense of identity I take to be the subjective correlate of ego-integrity. In the absense of ego-integrity or in disorders of the ego the sense of identity is correspondingly disordered. Ego-integrity is not a fixed state of solidity but must more appropriately be considered as a precipitate of the fluid interactions between the person and his environment. Put a bit more simply, a human being cannot long maintain himself in isolation and conversely his very human qualities are a constantly developing outgrowth of his relations with others. The work of SPITZ, ANNA FREUD, and BOWLBY has familiarized us with the sensitivity of the infant to absences of an expectable and reasonable environment as represented by the mother's capacity to provide a comforting structure. In adults the subtleties of the need for support of the ego are a bit more difficult to study. However, isolation experiments, sensory deprivation studies, and accounts of persons who have survived concentration camps are quite suggestive. The negative implications are probably clearer than the positive. When the environment, in terms of persons and institutions, ceases to make sense, when one's behavior no longer leads to a predictable outcome in terms of recognition, sensible responsiveness, or fundamental security, when the accustomed points of social orientation are removed, the individual is in danger of becoming lost, of vulnerability to 'brain-washing', of ego-disintegration, or even death.

In the United States military personnel are partially excluded from the greater society by virtue of their many moves. However, they have an opportunity for peripheral participation in a relatively permanent social system with its attendant continuity and security. In the absense of such participation there is often a tendency for a loss of the feeling that things were, that things are, that things shall be. With loss of that feeling there develops a loss of consequence within the community. This is reflected in the idea of transiency, of passing through, that one is here for only a short time, so what does it matter whether or not the place is painted, or has curtains, etc. In essence, when the grief that must result from the loss of context is not worked through either because it is unrecognized or because the ego is overwhelmed, there is great potential for narcissistic regression. This may be manifest in a variety of ways, including the use of the more primitive of the defensive operations, denial, distortion and projection. Subjectively, transient feelings of helplessness, and isolation

give way to projected anger and impotent rage. A simple manifestation in our patient population concerns their dealing with physical ills. People who present themselves in our Emergency Rooms often do so with the most minor of complaints, such as cold symptoms that have been present for a week. Their sincere belief in their own suffering and their anger should a physician interested in 'real sickness' fail to take them seriously often paints in miniature a picture of frustrated communication of needs for nurturance. The important point is that both the physician and patient experience the feeling of impotence and anger. Both are experiencing a sense of helplessness which is denied and projected. In duty situations these feelings of personal helplessness and isolation may be expressed among co-workers as a projected accusation of inefficincy. In the work situation the individual feels he is the only one who 'cares'. He is the only one who 'understands' the mission and feels that others around him do not pull their share of the load either through lack of ability or poor motivation. The difference between this attitude and that of adaptive criticism possible among individuals who are truly coping is that persons whose ego-integrity remains intact are able and willing to offer constructive suggestions for improvement of work conditions and increase of efficiency rather than working at 'building up a case' to show how ineffective everyone else is.

In our attempt to meet our responsibilities within the Command, within the community and its administrative structure and within the Center itself, consideration of this potential for regression led us to the familiar situation of regression under controlled circumstances, the psychotherapeutic situation, itself. There, one of the major safeguards of ego-integrity is the therapeutic contact, the agreement between the two participants as to their purposes and goals. The need for restatement of the original contract as therapy progresses and the transferred demands of the patient become so great as to threaten the very existence of the relationship, is a familiar experience of all of us. It represents one of the ways in which the therapist strengthens the reality testing of the patient and supports his ego. Actually, he does more. By restating what each party is there to do, the therapist is setting limits within the relationship and is clarifying the ego-boundaries of each of the participants. Both parties thereby maintain the sense of self-esteem and of identity. The ego-integrity of both therapist and patient is strengthened.

The application of this concept in meeting our Command-wide obligations and in dealing with sources of referral and patients outside of Wies-

baden has been the weakest part of our project. Let us examine the problems we faced. The Center had had its origin as a community clinic of a kind, providing parent counseling of a short term nature, and diagnostic testing, especially for special education candidates. Through personal contact of great skill by the social worker, JAMES KENNY, excellent community relations had been built. With increase in staff, expectations were heightened for help with local problems. On the other hand, some feared that new responsibilities for the children outside the local area would take so much time and attention that the Center would no longer 'care' for Wiesbaden. An additional and recurring problem has to do with staff turnover. Good relations that developed by one supervisor and his staff have to be re-developed following annual personnel turnover. Personnel outside the Center who knew its work and were instrumental in its support rotated and their replacements had to be made acquainted with the Center. Outside the local area we anticipated that expectations of what we could do might be far from the reality. We anticipated that referring physicians unacquainted with the limitations on the *usual* child guidance center would easily be disappointed and frustrated by the limitations inherent in *our* organization, particularly concerning the availability of therapy.

Directly we set about on a policy of clarification of our capabilities and, on all levels, with parents, with referring physicians and schools, and with administration, we began a policy of sharing, of mutual participation. In conferences with physicians and school personnel and indeed at any opportunity for public discussion we explained some of our limitations and our operating procedures. As a beginning, we realized that long-term therapy was not possible because of limitations in manpower and because of specific prohibition in our mandate from General DISOSWAY. We could, however, perform a thorough diagnostic evaluation at one time and in one place, using all of our skills plus the skills of other medical departments such as Pediatrics and Neurology. In turn we would offer our skills to these departments as consultants on their ward cases.

To obtain a more complete picture of family dynamics, we insist on seeing both parents and child, using air evacuation as a means of bringing the whole family to Wiesbaden. Rarely, have we failed to see the whole family. This is somewhat unique in Child Guidance practice as in most civilian clinics the father's role is frequently given only lip-service. After conclusion of a work-up we offer a thoughtful planned presentation of our results and recommendations to the parents. To our referring source

we send a concise summary statement of examination results, diagnostic impressions, and recommendations. This is couched in more professional terms than is our discussion with parents and we invite further inquiry for we maintain the confidentiality of our families, disclosing data on a need-to-know basis. Follow-up visits are encouraged. With many of our referring physicians we maintain telephone contact. Extensive personal visits have not been possible due to shortages of funds but we are in the midst of trying to develop a more adequate consultation program. We recognize a need to acquaint ourselves with the environment of our patients first hand. In USAFE, with its widespread bases and diversity of local problems, it is essential in the face of nonavailability of psychiatrically trained workers, to develop more active liaison with those people at the local level currently engaged in caring for the children. A recent survey done by the Center disclosed that primary responsibility fell upon pediatricians although other personnel are often involved. Often these people although untrained in specifically psychiatric disciplines, are already involved in the work by virtue of their willingness to accept responsibility. With specialized professional consultation from the Center they would have greater assurance of support and their skills extended thereby.

Locally, in addition to work with parent groups and specific involvement with special education, we send two of our staff regularly to the schools to act as consultants to teachers and administrators. This serves the Center as a screening device for cases but in addition is yet another means of explaining ourselves to the community. In all that we do we avoid the assumption of total responsibility and strive to maintain that sharing is implicit in the concept of consultation. It is often easier to view the specialist as having magical powers and it is a great temptation to avoid dealing with a problem child and instead to 'send him over to the head-shrinkers and let them take care of the problem'. This omnipotence we refuse to pretend to assume. For example, when a power struggle developed in one department within the school system our representative tried to avoid becoming a part of the conflict between teachers and administration. He did listen to each. His goal, instead, was to make clear the Center's role as consultant. The Center could not and would not make decisions properly reserved for the school. This was particularly painful for us as two of the children evaluated by us were at one point the subject at issue and were dismissed in spite of our previous recommendations. Our position of neutrality has frequently placed us in the role of intermediary between teacher and administrator. This occurs because the schools are

also understaffed and have no one formally assigned to this role. In this capacity we are often able to facilitate communication. From our own point of view we acquaint ourselves with the divergent but valid outlook of both groups.

From the overall administrative viewpoint, that is from the viewpoint of administrators outside the Center but involved in its functioning in some way, this new clinical operation has been a problem. Not conventional in military medical history, and difficult to justify in terms of the concept 'battle-ready', the Center is performing medical diagnostic work and by being potentially available to his family, it supports the security of the combat-ready airman.

One example of misunderstanding developed around the reporting of patient load. Originally, there was much concern with the question of how many patients we could see in a day. An answer is difficult to give. We felt the question reflected an unclear notion of our work on the part of administrators and deserved clarification of how we do our work. On the other hand we asked ourselves, are we doing better work if we see five patients or fifty. Obviously, sometimes the one is true and sometimes the other. Here, however, we misperceived the interest being shown. Our reporting of case statistics differed greatly from conventional military methods as we continued to count a patient as one case as long as he or other family members continued to come. Failure to report case load by the actual number of visits and by the actual number of persons resulted in falsely low numbers of patients reported. Also, many areas of the clinic's functioning seemed to be unreportable although staff time was involved. School consultations was one example. A study was made of our methods of reporting and as an outgrowth it was decided to change the system to conform more closely to conventional clinical practice. Some modification still had to be made to take into account cases handled by consultation with another clinic or physician or within the schools but not actually seen in the Center itself.

Another problem has arisen with funding. Organizationally, the Center derives support from several different sources within the community, rather than being strictly a part of the medical department. This is clear from the varied sources of funding. Salaries come from non-appropriated sources. Materials and supplies come from the appropriated medical channel. We are eligible for support from local base welfare funds for sundry items, such as toys. It has become important to let each of our 'rich uncles' know what the extent of their participation means to our

functioning. Otherwise it is possible to create the erroneous impression that because one department accepts a part of the responsibility, the help of the others is no longer to be needed or appreciated. The converse is that one funding source may be afraid to support a request for fear we will become an even greater responsibility. To clarify this point it is our policy to stress the shared nature of the support we receive. This is of course complimentary to the variegated service we perform, involving local and command projects. Thus, we can honestly ask for the support of many elements in the community and in turn offer service to the many different sources requesting it.

In a sense we have enlarged the concept of the therapeutic contract. Instead of two individuals we have considered the Center as joining with the community in a common effort. In application at any particular time we may be involved with any one agency, administrative channel or special function. With each we attempt to work out adequate guidelines for mutual respectful interaction. Someone may well ask, 'Why all this bother? Won't simple politics do?' We believe it will not do. Therapeutic aims have frequently run afoul of administrative means where there has not been careful attention given to the needs of each. Our situation is particularly vulnerable because of the factors already mentioned: the newness, the military context, the foreign location and the attendant stresses to which we are all subject.

The effect of these stresses within the Center itself deserves attention. If we are concerned with caring for others, Charity in the ancient sense of *Caritas,* we must first care for ourselves. The staff members of the Center are subject to the very same stresses as are the rest of the personnel of the Air Force in Europe. They have the advantage of a trained capacity for insight and an obligation to maintain their own integrity lest their work with patients suffer.

The differing backgrounds and training made for considerable differences of opinion as to the best means of solving the problem of meeting our many responsibilities. In addition, the lack of traditional long-time functioning made the staff uncertain as to their professional roles. The status of the clinic as non-appropriated from the salary standpoint, prevented staff members from acquiring longevity credit and disadvantaged them as far as pension and other benefits were vonverned. This fact contributed to job insecurity. The feeling of being experimental and a pilot project generated enthusiasm but also anxiety. Thus, when we were called to handle emergency cases such as a suicidal adolescent, the staff pitched in

with great fervor and many of the irritating details of everyday functioning lost their nettle as the clinic took on perspective. On the other hand, uncertainties about their own role and that of colleagues became evident at times of relative quiescence. Staff members would examine each other in performance of duty and complain that one or other of them was not bearing his full load of work. From time to time the small frictions of day-to-day contact would ignite into sudden bursts of fury. From time to time different cliques formed and dissolved. Communication between and among staff members was, to say the least, difficult.

Various approaches were made to resolve these intraclinic difficulties. Staff meetings were first held on a daily basis, then cut down to twice a week. An academic staff was organized wherein staff members could present their work and special interests. This was intended to acquaint the staff with one another's functions and to increase mutual respect. Some patient interviews were jointly handled by staff members, both for professional reasons and as a device whereby staff members could see each other in operation and learn from one another. Each staff member was given some supervisory time on a continuous basis either by the Director or the Assistant Director. Administratively, efforts were and are being made to upgrade worker positions and to increase job security by providing greater benefits and by making the positions more equitable with those of non-appropriated workers in the same grade.

In all that was done the basic philosophy was that the center had an obligation to its staff and staff members had an obligation to one another to support and extend one another's functioning. It is customary at this point in such a narrative to enumerate the success of results. In our case there were indeed improvements. Particularly useful were the academic staff meetings and the joint interviewing of patients and families. However, it was not a uniform success. Molding a clinic staff into a well-functioning, well-integrated unit depends on common motivation for cooperation in spite of differences of outlook. This is the basis for any therapeutic contract as well.

Deficiencies in motivation for personal improvement and enhancement of overall clinic functioning are expectable as a reflection of the stress to which the staff, like other Americans in the military community in Europe, is subject. It has required prompt attention and intervention. For this professional group restatement of our goals and a detailed analysis of the problem has often helped us to refocus our efforts to the dual task of personal and professional adaptation.

In an overview it can be seen that we have attempted to carry into administrative practice those principles of therapeutic experience which promoted ego-integrity. Beginning within the clinic itself and professional and interpersonal relationships of the staff, we enlarged the concept of the therapeutic contract to include the community, first locally at the physical site of the Center, then Command-wide, the locus of responsibility. In our work, we took pains to define ourselves and our role and to make clear the terms of sharing responsibility with each partner of the contract, whether as an individual or as a representative of an organization.

At this point we have not reached all our goals. We would like to be in the position of being able to point with pride at all of our accomplishments. However, there is still much to do. We have not come to an ending but are still in the midst of our labors. This paper then represents an interim report as well as a theoretical framework and set of propositions whose outcome remains to be tested by time and reality.

Summary

With a newly-developed Child Guidance Clinic for the American military community of Europe as a model, the discussion builds the concept of application of the therapeutic contract to the development and maintainance of the multiple relationships between clinics and the various community agencies and patients they serve. Of the important relationships, those between staff members of the clinic are vitally important and form a major portion of the argument. This is true because of the ancient dictum, 'physician, heal thyself'. Charity, in its ancient derivation of 'caritas' or caring, begins at home.

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Author's address: J. Kuten, M. D., Instructor in Psychiatry, Tufts Medical School, 591 Morton Street, *Boston, Mass.* (USA).

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Social Institutions as Therapeutic Communities

C. V. Martin and G. C. Horner

Brandon Psychiatric Group, Kansas City, Mo.
(Director: C. V. Martin, M. D.)

Psychiatric literature abounds with references to the therapeutic community as applied to psychiatric situations, psychiatric hospitals and specific psychiatric social institutions [5]. At the other end of the continuum have been such books as Skinner's 'Walden Two' [15], describing utopias where every situation is seen as being therapeutic; so it naturally behooves those engaged in the behavioral sciences to seek to expand from the therapeutic community of the hospital to the use of other social institutions as being therapeutic. This paper will deal with three such institutions; the military, the school and the church. The institutions were organized to function in a therapeutic manner. The first two specific situations that will be described are those which have been formed, practiced and followed up [8]. In the third, a specific plan for implementation of the therapeutic community will be presented. For a definition of the therapeutic community we might turn to the chapter on the therapeutic community by M. Kraft in Vol. 3 of the American Handbook of Psychiatry [6]. Here the therapeutic community is a very special kind of milieu therapy in which the total social structure of the treatment unit is involved as a part of the evolving integrative process. It is organized and developed in order to make available for treatment purposes all relationships and all activities in the life of the patient. He further points out as characteristics of the therapeutic community emphasis on the social and group interaction, focus on communication, living-learning opportunities, sharing of the responsibilities with the individuals involved and lastly, role-expansion.

As one begins theoretically to plan a therapeutic community, he might wish that there were certain basic and fundamental rules to be followed

which would guarantee success for such an undertaking. What is needed, therefore, is a theoretical model to guide the actions of the various kinds of institutions and agencies that can promote individual development. If one looks to the behaviorist for such positive rules to fulfill the promises of 'Walden Two', one finds that most of the research is still in the stage of abstracting part-functions for experimental study and would fall short of the chosen goal to establish general laws of behavior. The main characteristic of such laws at this point is their lack of generality; they break down as soon as new variables are introduced into the picture. Since real life constantly presents new variables or variables not taken into account in the laboratory experiments, such laws are most limited in their applicability. Their claim at the present is for their *eventual* applicability in this kind of work; as SANFORD suggests in his book, 'Self and Society' [12]. He further suggests a more realistic, dynamic approach, pointing out that perception and learning can be abstracted from their personal contexts and also studied in and of themselves and that this is a common practice. It has been shown that when factual material is presented to subjects according to predetermined schedules of reinforcement, learning is more rapid and complete than in the usual hit-or-miss arrangement that they obtain in the classroom or in solitary study [14]. One has to remember, however, that from the point of view of dynamic theory, one should not expect factual content to be retained for long, no matter how efficiently it was learned, unless it became integrated with the individual's purposes. But how such integration occurs is a complex question which cannot be answered unless individuals are carefully studied over relatively long periods of time. RIEFF, in his book, 'The Triumph of the Therapeutic' [11], suggests marriage between the behaviorist learning theory and Freudian theory might lead to an eventual answer to this dilemma. The determination of human events is always complex. Multiple factors are involved and it is the task of the behavioral scientist to find them. SANFORD [12] points out further in 'Self and Society', for example, the phenomenon of compulsive drinking. A formula for this could be written out in terms of positive and negative reinforcements and in such a formulation the reproaches of the drinker's spouse might in some cases be put down on the side of negative reinforcement. But what about the case of the man who drinks in order to express hostility towards his wife and who welcomes her reproach as a sign that he is achieving his purpose? One could still describe what happens in stimulus-response terms after one had discovered what the effective stimuli were. But in finding the stimuli, the usual sort of learn-

ing theory and the knowledge that proceeds from laboratory experiments would be of little help. The quest would have to be guided by theory and knowledge concerning the complex interplay of forces within the personality. This background is used in an attempt to mould the two theories into a meaningful therapeutic approach.

The two therapeutic communities described and the one proposed are based on an attempt of such a theoretical union. Nor should one make the error of assuming that this approach suggests that all of psychiatric treatment *per se* should be taken out of the hospital and given to the institutions described. There is no doubt the psychotic belongs in the hospital, but one of the most difficult areas of treatment to date is that of the character and behavior disorder or personality disorder. As has been pointed out previously [10], families of members suffering from severe character disorders represent the most serious social problem in the USA. In financial terms these families account for large parts of current expenditures for public assistance, police departments, correctional systems, mental hospitals, child placement facilities and various other institutional and welfare programs. Apparently these families are not only the marginal workers described by economists, but they are marginal human beings in the sense that they live on the edge of life. Certainly, waiting for the character disorder to fall afoul of the law in order to provide the adequate therapeutic situation is not the answer. Each of the therapeutic settings to be presented here would be more likely to receive specific kinds of personalities because of the nature of the institution, and therefore would be particularly beneficial to such groups.

Therapeutic community in the military setting

The military is in the unique position of having control over individuals for a four year period in the USA and is under no legal obligation to prematurely discharge these individuals. The fact that such a structure can be therapeutic has been pointed out by PLAG and ARTHUR in 1965 [9]. So, from the behavioral theory framework that much of deviant behavior is learned behavior, but that it must also be seen in the context of dynamic interaction, a model for the military's therapeutic community will be presented [7]. In the military one has the ideal context of positive and negative reinforcements ready to be used in the system. When these are used in such a theoretical framework, therapeutic goals can be realized.

At Chanute Air Force Base such a therapeutic community was established. When an individual came to the attention of his commanding officer or a general medical officer in the military sick call because of emotional problems, he was first interviewed by his squadron commander in an attempt to work out the difficulty. If this failed, the individual was referred to the base counseling service which was a field placement service of the University of Illinois, staffed by the graduate educational counseling students. If, at this point, the individual's problem was so great that it could not be worked out there, he was then referred to the neuropsychiatric clinic with a report from his commanding officer as to the nature of the problem and an estimate of his then present military performance. Upon arriving at the clinic, the individual was given a battery of psychological tests. When he was first seen by the psychiatrist, the results of these tests were available. At the initial psychiatric interview the decision was made 1. to refer the individual to the airman's readjustment group which was a group therapy session meeting once a week with a psychiatric social worker. (This was the usual placement with continuation of ordinary military routine. The psychiatric social worker, working closely with the squadron commander, dispensed appropriate reinforcement contingent on the airmen's behavior.) 2. to admit the patient to the hospital if his problem seemed to warrant a brief exclusion from military life, never more than five days or 3. he might be returned to his commanding officer with a recommendation for administrative discharge and asked to wait in his squadron until discharge. After hospitalization, the individual could then be assigned to a day hospital. He spent his days in the treatment program at the hospital and his evenings with his military organization. There were approximately ten people in the hospital and ten people in the day hospital at all times awaiting administrative or medical discharge. The therapy milieu consisted of group psychotherapy for one hour each morning, occupational therapy and rehabilitation work programs and usually two individual sessions per week for psychotherapy. These sessions had to be initiated by the patient rather than by the therapist. There were, of course, limited goals in therapy. First, an attempt was made to show the individual, usually resistive, that his problems stemmed from himself; that it was not the rest of society that was wrong. Second, that there were reasons for the impulsive things that he did. Third, that there is an appropriate kind of treatment which could help him to overcome his personality difficulty. The day patient program provided substantial psychiatric treatment for the personnel with emotional prob-

lems while significantly reducing the pathological dependency needs of the patient that hospitalization might bring forth. The day patients remained under the cognizance of the psychiatric ward during the entire normal duty day. This involved a period of nine hours. Weekend passes were granted if the pass was considered to be of therapeutic value. After the normal duty day, the patient returned to the squadron where he was instructed to participate in routine squadron activities which prevented him from totally withdrawing from an environment which has stress similar to that of civilian life in terms of human relationships, relation to authority figures and social expectations. The day hospital was less authoritarian and stressful than the squadron but not as protective as the hospital. Daily group therapy sessions were conducted jointly by a psychiatric social worker and psychiatrist functioning as co-therapists. Having a co-therapist was advantageous for several reasons. Emphasis upon intrapsychic problems by the psychiatrist and on the interpersonal problems by the psychiatric social worker helped the patient to gain better insight into the depth and scope of his problems. In many instances significant material unobserved by one therapist was often detected by the other. Finally the co-therapist concept substantially reduced the stress on each therapist and enabled him to guide the group along more meaningful lines. Since the goals of the group were as described, the therapists avoided functioning in the traditional passive manner. The patient came to realize that his personal problems caused him to have social difficulties. The therapists confronted the patient with this phenomenon so that the patient himself could look closely at the underlying nature of his problems. Evaluation of the program by contacting individuals two years after their discharge indicated considerable social growth after the two year period, and the group that received treatment showed considerable improvement while those not receiving treatment and awaiting discharge in the squadron showed less improvement. The anti-social personalities, the inadequate personalities, and the emotional instability reactions, the schizoid personalities, all showed a good deal of growth. Passive-aggressive passive and passive-aggressive aggressive individuals showed the least improvement in this situation.

The school as a therapeutic community

Marillac School in Kansas City, Mo. is operated by the Daughters of Charity of St. Vincent DePaul and is organized as a therapeutic com-

munity. Marillac has developed a program of education which is designed to provide a therapeutic atmosphere for learning through its educational and psychological services for children of elementary school age who are approximately average in intellectual ability but unable to learn at a reasonable rate due to some emotional disturbance. All of the subjects are taught to small groups numbering five to seven who are carefully matched in terms of native ability and previous academic achievement. The skills presented are reinforced through class projects and activities. The grouping is kept fluid with the individual and group psychotherapy with a teacher, therapist and a psychiatrist, working very closely to make sure that the entire atmosphere is therapeutic. Before the child is admitted to the school complete psychiatric, psychological, educational and social background studies are done. The child is then placed appropriately with regard to educational level for each subject, group or individual psychotherapy, and medication. His parents are also seen in therapy. This is a mandatory part of the program at the school to extend the therapeutic atmosphere on into the home through behavioral techniques.

The initial phase of a comprehensive study designed to determine the effectiveness of the school has been completed. The total study will include 160 children who have attended and left the school since 1962. The initial phase included 40 children selected at random from the 160. The results of this preliminary study are presented.

The forty subjects had a mean I. Q. score of 87.7 as determined by the Wechsler Intelligence Scale for children. The mean number of years spent at Marillac was 3.4 and the mean number of years they had been out of Marillac was 2.1. Of the forty, 100 % were still attending school, either public or parochial. As determined by parents' reports, 45 % were said to be making average grades, 45 % below average grades, and 10 % above average grades. None had failed or repeated any grades since leaving Marillac, although 70 % had failed one or more grades before attending Marillac. Forty-five per cent or not quite half, were still in some form of special education. The remaining 55 % were attending regular classes.

Although the number of subjects in this initial phase is not complete, the results are indicative of the therapeutic value of such a program. Although the study sampled children that have left the school during the last four years, it has been only in the last two years that enough trained, professional people have been available to bring about the total therapeutic program desired. This means that while all the children were getting the

proper educational experience, they were not able to get all the therapeutic help considered desirable. Now, however, each child obtains the total program. Students are not admitted unless this can be assured.

It is encouraging to view these intermediate effects of a school based 'therapeutic community'. These results obtain even more significance when it is realized that 21 of the 40 subjects had I. Q. scores of 89 or less. Thirteen of these 21 fell into the border-line range of 79-62. Certainly it should stir the interest of behavior scientists to discover what results might have been possible had the school had access to these youngsters during the more formulative years of 1 to 5 in addition to some of their elementary school years.

This brief section indicates quite clearly the usefulness of the 'therapeutic community' concept as it is related to the school as an institution. A more total therapeutic environment has unlimited possibilities as it is related to such a situation.

The projection of the church as a therapeutic community

In many ways religion can be used by the neurotic as pointed out by FREUD [2]. One use of the religious experience by the neurotic is as a mechanism of defense against anxiety; anxiety that is brought about by repressed emotions such as aggressive impulses, hostility, resentments, and the ultimate death anxiety which are often found to be unacceptable to the 'self'. These impulses are thought to be self-destructive and considered 'not nice' and necessary to be repressed by the neurotic. If the church is to become therapeutic, it is this group of people that would benefit most. In what way then does the church move into the area of the therapeutic community? Certainly during the 1950's there were great advances in church membership and there was a great revitalization of church life. Growing into adulthood during this period in the USA one had the feeling that the church had indeed found the relevancy for modern man. However, growing into maturity during the 1960's one finds that the church seems to have lost its relevancy or else it had never truly found it. Statistics continue to show that church growth is not keeping pace with population growth and that church attendance is again down. People, however, continue to search for personal identity, personal relevancy and personal meaning. The search very often takes the individual into a one to one relationship with an individual called a therapist. In the July, 1965

edition of 'Mental Hygiene', COBB *et al.* [1] states that there is an extreme acceptance of counseling by clergymen as a legitimate function of the profession. They say that this is reflected in the shift from counseling as a round of pastoral calls, to a more formal concept of the counselee seeking appointments in their study.

The setting has then become similar to that of the psychotherapist. In the February, 1966 'Together' [4] GILDEA, in an article called, 'The Crusades in Counseling' suggests that there are abundant signs that the church's interest in mental health has taken great strides. To date, most of the attempts are in the area of the traditional guidance clinic in the church setting. The suggestion then that the church has a therapeutic role is largely accepted, but the whole church as a therapeutic community is relatively new even though the elements are there: social and group interaction focus on communication, living-learning opportunities, sharing of the responsibilities with the individuals involved and role-expansion. The church culture must become one in which there is a favorable climate for: 1. helping the individual to gain an awareness of his feelings, thoughts, impulses and behavior, 2. helping the individual to try his new skills in a relatively safe environment and 3. helping the individual achieve a realistic appraisal of his social and interpersonal environment, and 4. helping each individual to increase his self-esteem. In his book, 'The Art of Loving', FROMM [3] points out that love is a function of mental health. SCHOFIELD [13] in his book presents very well the thought that psychotherapy is the purchase of friendship.

Certainly then, it would not seem incongruous to present these as a part of the function of the church. It means making the church experientially oriented and certainly people have been calling for this over the centuries. To a large extent, most protestant Sunday schools are group oriented although many continue in a traditional preaching role which has been shown to be as ineffectual as the typical lecture is as a method of learning. These small groups, instead of meeting to read some Sunday school material, should meet on an experientially oriented basis, attempting to reach the goals as outlined above. Since staff and other individuals would be able to confront members of the group with the realities of the social situation and with potentially helpful or destructive aspects of their behavior, it thus becomes potentially therapeutic. This means, of course, finding a group of leaders who are so oriented, which in turn means setting up training laboratories which also operate on a group therapeutic level.

The final and ultimate aim in all these institutional experiences is to offer enough therapy that finally the basic social structure of the family might also become therapeutic in its function and make-up. That the vicious circle of emotionally disturbed parents causing their children to be emotionally disturbed might at some place be broken. Major emphasis in the United States today is on the federal government offering funds for mental health services, but this offers a possible basis for an Orwellian society, whereas if we broadened the responsibility, using other institutions in therapeutic ways with the decentralization of therapeutic power, this difficulty is less likely to evolve.

Summary

The psychiatric literature contains numerous references to the possible use of established social institutions as therapeutic communities. However, very little data is now available concerning the implementation of these programs. This paper deals with three such programs; the military and the school, which have been formed, practiced and followed up, and the church for which a specific plan is presented. It was necessary to integrate several theoretical approaches in order to obtain the necessary control over the patient's environment. It is hoped this will lead others to initiate programs whereby ongoing social institutions may be made more therapeutic.

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Authors' addresses: C. V. MARTIN, M. D. and G. C. HORNER, Brandon Psychiatric Group, 15 East Gregory Boulevard, *Kansas City, Mo. 64114* (USA).

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Therapeutic Community Principles within the Hospital, and in the Outside Community

M. JONES, Melrose

The term 'Therapeutic Community' originally applied to psychiatric hospitals or special units with a particular type of social organisation. Instead of the familiar hierarchical, authoritarian organisation associated with hospitals in general, the therapeutic community aimed at a more democratic, egalitarian type of social structure. The aim was to bring about the optimal use of the potential within staff, patients and their relatives, for the betterment of the patient population. With the rapid growth of community psychiatry in the past decade the focus for treatment has tended to move from the hospital to include the outside environment from which the patient came. The resources of the helping disciplines outside the hospital have come to have a new importance as has the potential help which the patient's family and immediate contacts can provide. The concept of primary prevention has highlighted a growing awareness of the possibilities for preventing psychiatric illness, as has the increasing interest in health education, modification of adverse community attitudes towards mental illness, and so on. In brief, the concept of the therapeutic community in the outside community, although much more complex and intangible than the hospital therapeutic community, has a certain amount of validity and will be discussed in this paper.

Five fundamental concepts of the hospital therapeutic community will be discussed, and after each item the relevance of the concept as applied to the outside community, will be examined [JONES, 1968 a, b].

I.

One of the first principles of a hospital therapeutic community is the establishment of two-way communication at all levels. In the familiar,

hierarchical social structure, communication downwards may be efficient but there may be relatively little feedback from the lower levels of the hierarchy to the centre. A two-way communication system, involving all levels of staff and patients in the hospital, implies an overall sharing of interest in hospital affairs, and a relatively high status for patients, and for staff at the lower echelons. In other words, the attitudes and opinions of the patients and junior staff are seen as important and an appropriate amount of time must be devoted to communication from these areas.

Two-way communication in the outside community is obviously much more complex than in the relatively small microcosm of society represented by a hospital. Democratic governments, with their elected delegates, are an attempt at two-way communication, with feedback from the constituency to the elected delegate who, in turn, may bring matters of sufficient importance to the notice of the Government. Local Government also attempts to operate on a somewhat similar model, but when tens of thousands of people are involved it is difficult to establish priorities and the effectiveness of such a governmental system is determined in a large measure by the quality of the individuals operating the system. The importance attributed to mental health by any one national government, or local government, will depend on many variables, including the competing priorities, the quality of the government officials, and so on. The education of the general public to a better awareness of the part that they can play in helping and preventing mental illness, is being attempted by Associations of Mental Health, and similar bodies. The teaching professions, if given better instruction, might play a much more active and useful part than they do as yet, and some simple plan, such as an attempt to arrange for every school drop-art to visit the local psychiatric facility, might do more to alter the distorted ideas about mental illness than any amount of formal education. In my experience, children quickly respond to the psychiatric patient as a person and learn the true state of affairs for themselves by personal involvement with the mentally ill, with some help from trained psychiatric personnel.

II.

The establishment of a decision-making machinery at all levels of the hospital organisation is another characteristic of a therapeutic community. Staff are trained to perform various functions and have varying degrees of responsibility. The amount of decision-making and responsibility which patients can undertake will also depend on many variables, including the

clinical state, education, socio-economic status, staff expectations, and so on. It would seem that, in general, patients are given far too humble a role to play and the advent of group therapy, ward meetings, and therapeutic community practice, have all tended to raise the status of patients so that they can assume far more responsibility than previously, in not only getting help for themselves, but in helping others. It seems obvious that any decision involving staff or patients should involve these individuals in the decision-making process. All too frequently, however, decisions are made by some higher authority without adequate involvement of the individuals who will be carrying out whatever decision is arrived at. Such decisions imposed upon the people directly concerned are inevitably seen as impositions from above. This leads us to a consideration of the use and abuse of authority.

Decision-making at all levels of society outside the hospital is clearly dependent on the social organisation of the outside community. In a democracy, we like to think that people have an opportunity to participate in decision-making in matters which concern them but it is far from easy to realise these goals in practice. In Britain, the establishment of a Royal Commission on some important social issue, allows a body of informed appointees to obtain evidence from experts in the field. Such a committee, by interaction with the various individuals and committees interviewed, provides a rich educational experience. As a result of this, a Royal Commission is able to make recommendations of a far more representative kind than would have been possible had the committee been denied the opportunity of communicating with the various individuals from the field under scrutiny. The Mental Health Act (1959), in Britain, was a direct result of the invaluable Royal Commission on Mental Illness and Mental Deficiency which preceded it. In the USA, the Final Report of the Joint Commission on Mental Illness and Health – 'Action for Mental Health' – (1961), served a somewhat similar function in that country. In Britain, new legislation is pending which attempts to integrate the various social organisations concerned with all aspects of social distress, including mental health at the local level; but much remains to be done before local communities can feel that they have much say in decision-making in matters regarding mental health.

III.

Leadership in a hospital therapeutic community is of outstanding importance. A therapeutic community implies that leadership will be shared,

and responsibility and authority delegated, as far as practicable. It seems to me that one of the stumbling blocks in the evolution of a hospital therapeutic community is the abuse of authority, particularly as represented by the upper echelons of the medical profession. The professor in a medical school, or the physician superintendent in a psychiatric hospital, tend to have an inordinate amount of authority and power. The temptation to abuse such a position, and make unilateral decisions without consulting all the people involved, is considerable. This applies particularly in times of stress when authority figures may feel threatened and obtain some reassurance by making autocratic decisions. Medical training is based on the hierarchical system, which prevails in virtually all hospitals, and all too often results in a feeling of omnipotence in a newly trained doctor, which has little or nothing to do with true leadership. As far as I know there is no serious attempt to study problems of leadership and how to train leaders, in any of the medical schools. Nor do doctors tend to be good listeners, and are therefore not favourably placed to learn from junior members of staff, or from patients and their relatives. In my opinion, leadership in a psychiatric team can only be learnt by the day-in, day-out examination of what the staff are doing and why they are doing it. A daily ward meeting, followed by a staff review, affords such an opportunity to examine the reaction of various staff members with different personalities and training, to the same staff – patient interaction in the ward meeting. By an analysis of what went on in such a ward meeting, staff members can examine their own perceptions, and compare their own experience with that of other staff members. The senior doctor, who is usually the leader in such a situation, is himself available for scrutiny and his performance discussed so that he is in just as favourable a position to learn as are the other staff members. It may be that the psychologist, social worker, and senior nurse, are all potential leaders, and by such a daily examination of staff – patient interaction, the concept of multiple leadership can readily emerge. It seems to me that unless such on-the-job training is available, doctors are liable to assume leadership by a sort of divine right, and will frequently fail to make optimal use of the other disciplines involved in psychiatric practice. They may also fail to listen to the junior staff members and patients and their families.

Leadership in the community presents far more serious problems than in the hospital. However, there seems to be every reason to think that pychiatrists who have been trained in leadership in the way that is suggested above, will find it relatively easy to communicate with, and learn

from, the natural and elected leaders in the outside community. In fact, the success of community psychiatry could be said to depend more on the capacity of the psychiatrist to utilise leadership in the community, than on any other single factor. Unless the psychiatrist approaches the family doctor, the local authority officials, and the welfare agencies, with having at least equal status as members of the outside society, there will be little hope of an integrated service for the mentally ill. An effective community psychiatry service must await the time when multiple leadership in a multidisciplinary setting has been achieved.

IV.

The concept of consensus in a hospital therapeutic community is a particularly difficult idea to put across in words and is much easier to demonstrate in practice. It is reasonably easy to decide when agreement has been reached in a democratically organised decision-making group. Thus, a senior staff committee may discuss the problem of integration of sexes in a psychiatric ward. If everyone feels that such a decision would improve the lot of the patients and not create serious difficulties in other parts of the hospital, or in the community outside, then action is taken. If consensus can not be reached, this seems to indicate that further examination, discussion, and analysis of the problem is necessary. The principle of consensus implies that any decision taken without such agreement, may well be a bad decision, and it is better either to postpone the decision until consensus can be reached, or drop the matter altogether. Frequently, it pays to leave an undecided issue on the table and if there is much interest and motivation on the part of some of the sponsors, it will be revived at some later date, when people may be ready to come to some compromise agreement. Alternatively, the matter may simply drop out of sight, implying that the matter under discussion was not of great importance.

Decision-making by consensus would seem to have, as yet, little part in decision-making in society outside the hospital. The system of voting in parliamentary circles is very different to the type of consensus we have been talking about. Whether or not this is an important concept in the community practice of mental health, remains to be seen. It would seem to me to have important links with family therapy and could be said to be one of the explicit goals of such therapy.

V.

Social learning in a hospital therapeutic community implies two-way communication, with the expression of feeling, and an analysis of social interaction. Such social interaction would include ward meetings, followed by staff review, a group treatment session, informal groups, or social interaction in any here-and-now situation. The amount of social learning which occurs will depend on many variables, including the freedom with which people can communicate, the degree of security which is necessary for the expression of intimate feelings, and the skill with which the social interaction is analysed. The latter implies leadership, with group analytic skills. Teaching can be seen as one-way communication that directs knowledge from the teacher to the pupil. There is little or no opportunity for two-way communication in the average classroom. Such teaching is not to be devalued as there is no way of avoiding the necessity to accumulate a great deal of knowledge through this form of communication. Learning, on the other hand, is a social process dependent on two-way communication and the exchange of ideas between teacher and pupil. In my opinion, a therapeutic community makes use of every opportunity to invoke social learning. This applies not only to formal instruction of staff, as in T-Group training, or sensitivity training, but also implies the utilisation of any crisis situation involving staff or patients. Such a crisis situation calls for confrontation of the people involved in the presence of skilled, uninvolved leaders, so that the problem is analysed as objectively as possible with a view to learning what lies behind the behavoir and the emotions which are aroused. Opportunities for social learning abound and are not only limited to the staff. Ward meetings, particularly when feelings are aroused, lend themselves to social learning, as do crisis situations on the ward, when a spontaneous group should be formed immediately so that the crisis can be turned into a learning situation. From what has been said, it will be clear that I make little distinction between training of staff and treatment of patients. Indeed, I personally have come to feel that it is better not to use the word 'treatment' at all in the practice of community psychiatry and to substitute the term 'social learning'. In my opinion, social learning leads to maturation of staff and of patients, particularly when their families are involved.

Social learning, as applied to the outside community, has, as yet, achieved little place in community living. Our educational system, whether in schools or universities, pays remarkably little attention to this aspect

of learning, and the whole concept of a professor seems to be the antithesis of what we are talking about. Unless the professor is prepared to become the subject, when this is appropriate, and have his performance analysed along with any other individuals concerned in a crisis situation, it would seem that the professor is not in a position to benefit from social learning. Since such an approach to learning is relatively absent from our educational institutions, it is not surprising that the community at large tends to neglect such a rich opportunity for growth.

Summary

The social organisation of a therapeutic community in a hospital can usefully serve as a starting point for the development of a blueprint for *social organisation* in the community. The same applies to *function*. Community psychiatry offers an immensely exciting challenge for the future and much will depend on the training which people in psychiatry and the allied disciplines receive. Hopefully, training can do something to offset the abuse of authority, the struggle for power, and the isolated position that is adopted by many disciplines when coordination or integration is called for. However, the mere existence of community psychiatry suggests the need for tremendous changes in the attitudes adopted by the relevant professional groups and by the community at large.

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Consultation with a Group of Wardens from the London Area of the Y.W.C.A.[1]

MARGARET ROBINSON, London

The idea of having a group of wardens to discuss relationships in a residential setting arose from a talk which the author gave at an in-service training meeting in March, 1956. This was to a group of hostel wardens from the Young Women's Christian Association which runs hostels and clubs for women and girls throughout the world. The wardens felt that this stimulated their interest in human relationships in their hostels, both between the residents themselves, resident–staff relationships and staff –staff relationships. The Training Secretary of the London Area of the Y.W.C.A. who is responsible for the in-service training felt that regular meetings of an interested, selected group of wardens would develop the wardens' skills in handling the many difficulties which arise in day to day living within the hostels. It was decided that the course should be planned by the Training Secretary, the Hostels Adviser (who is responsible for overseeing and assisting the wardens in the smooth running of the hostels in every way) and by the Consultant. These three met to outline the course, to select the wardens who were invited to apply to attend and to fix the place and frequency of the meetings.

Planning and structure of the group

There were in all, three 'courses' or groups of meetings: each of a sligthly different character, as we groped to find the most appropriate. The first group of meetings began in the Summer of 1965. These were attended by ten wardens, the Hostels Adviser and the Training Secretary and the Consultant. Initially it was decided to hold the meetings monthly for an hour and a half and to meet at a different hostel each time. This threw into

[1] Young Women's Christian Association.

relief the rivalries between the wardens, not only in the differing accoutrements of the hostels but in the differing types of hostel. The wardens were representatives from four main types of hostel, the new 'cluster' type hostels, where the girls had single or double rooms grouped round a kitchen and living room and catered for themselves, the 'transient' hostels who catered for women and girls who only required temporary accommodation, the more traditional shared 'dormitory' type hostels with some single rooms; and those where in addition to a small hostel there was also a club on the premises. After the first few meetings it was decided to meet at the Central Y.W.C.A. as this was more central and therefore made travelling easier, and also avoided stimulating the rivalries between the wardens and their feeling that their domestic capabilities were being judged by the group when the meeting was held in their hostel.

The first course was somewhat haphazard both in structure and in form. This seemed to stem from the new experience of wardens learning a professional approach to the task of the group. There were also uncertainties about relating this learning experience to the job situation and the actual life and work of the hostel. The staff members of the group, that is, the Training Secretary, the Hostels Adviser and the Casework Consultant, were also testing their own roles within the group and learning about relating with each other to maintain the primary task of the group. There was also a need to clarify their roles and the sensitivity to each other was developed as was the growing awareness and understanding of what was happening in the group. For example, some difficulties had to be worked through by the three staff members outside the group, e. g. the Casework Consultant's ignorance of who was responsible for what within the Y.W.C.A. framework and hierarchy.

After this first experiment the wardens themselves asked for a more structured course and it was agreed the Casework Consultant should give a series of ten lecture-seminars on human growth and development. The Consultant reluctantly agreed to do this and encouraged the wardens to discuss in the group 'problem residents'. Throughout this time there was a good deal of hostility expressed about psychiatric personnel and looking back it seems likely that the wardens were testing out the Consultant, and also perhaps attempting to reality test their own phantasies of the magic that psychiatric skills could achieve. They did at this time put great pressure on the Consultant to see and assess difficult residents and this was dealt with in reality terms of it being uneconomic in terms of time and

inappropriate when local psychiatric services were available if necessary.

At the end of the second course the Training Adviser felt that she should withdraw from the group, which was now a going training concern, but continued to act as liaison officer and was consulted about any new changes in structure. The structure of the third course has become a more familiar one in that the wardens decided to either send in, or present spontaneously, problems for discussion and it seems likely that this kind of pattern will continue. Some of the wardens have attended all three courses and have provided a nexus of support and continuity for the group. They are now wanting to extend the group, and encourage the more diffident to join, as it has been a voluntary exercise up until now; and are prepared to withdraw themselves if necessary.

The role of the warden

The warden's role in the past was seen predominantly as a combination of three functions: 1. domestic bursar and director of the building, 2. an authority figure, 3. the staff member of an association, i. e. the Y.W.C.A. The actual interpretation of these functions vary according to the inter-relationships of the warden with the girls and with warden and the Y.W.C.A. There are also the attitudes of the community and how this impinges on the way the warden interprets her complicated role.

These three functions have been changing over the recent years. For example, with improved architectural planning and structural alternations and with technological advances, the warden needs to spend less of her time directing the hostel, though she has to spend more time filling in domestically because of staff shortages. The Y.W.C.A. as a staff association is changing too. There seems to be a feeling of freedom to innovate and improve, coupled with anxieties about damaging the image of the Y.W.C.A. as a good solid Christian foundation. But the biggest changes are in the area of the wardens' authority. With the increasing freedom and confidence of young people for whatever reason, the gap between the warden up there and the girls down there, is closing. Authority figures are not so remote, girls are less prepared to comply with rules and regulations and feel more free to test out their changing attitudes to authority with the wardens. There is a tremendous turnover of girls who often use the Y.W.C.A. as the last base on the road to independence. They come to the hostel, form into small groups and then move off into a flat. Some of them don't last and return – is it the warden's job to ask

herself and perhaps the girls, why didn't they make out? How should the warden's attitudes change to cope with this diminution of the authority gap? How can she meet the girls on their own level and yet retain enough authority to meet the needs of the smooth running of the hostel within the Y.W.C.A. framework?

Relationship of the Hostels Adviser with the Consultant

Our awareness of how important this relationship was developed as the group progressed. It became apparent that the group constantly tested out our goodwill towards one another and our ability to delineate our own roles vis à vis each other and the wardens. The Consultant was the leader of the group, but always deferred to the Hostels Adviser on domestic matters and on points where the policy of the Y.W.C.A. were clearly involved. The Consultant was careful not to undermine the authority of the Hostels Adviser and she in turn deferred to the authority of the Consultant in matters where emotional difficulties were apparent.

It seems likely that the shared responsibility of the Casework Consultant and the Hostels Adviser for the running of the group provided a model for the wardens sharing responsibilities with their deputies.

Main problems in hostels

The wardens were able to gain much mutual support from one another in finding that many of the difficulties which they experienced were common to them all. These problems can be roughly divided into the following categories:

1. Epileptic residents

It was found that many epileptic women did not tell the warden that they had epilepsy when they applied to become residents. There was at first, some hostility about this behaviour until it emerged that many of the wardens would in fact refuse to accept an epileptic because of the concern that this might cause to the other residents and possible danger to the resident. However, they discovered that when a resident settled in the hostel well and proved easy to get along with and then was discovered to be epileptic, that they were prepared to do all they could to assist them, provided that they knew from the resident that their epilepsy was under medical control and they felt the resident had come to terms with their illness.

2. Attempted suicides among residents

Almost all the wardens had had experiences of residents attempting to commit suicide, either by overdoses or by gassing themselves. Two of the wardens had been nurses and were able to give the others practical advice about this. There was considerable anxiety expressed about fears that the wardens might not have been able to prevent this action and also the harm that this might do to the good name of the Y.W.C.A. Some of the wardens of the 'transient' hostels seem to have the experience of residents coming to their hostel and almost at once attempting to commit suicide, when the warden had had no opportunity to attempt to assess the emotional state of the resident.

3. Emotionally disturbed residents

These could be divided into two categories, those who were, often unknown to the warden, already psychiatric patients and were either discharged mental hospital patients, or attending out-patient clinics or General Practitioners who were prescribing for them. The wardens expressed some hostility both towards psychiatrists who regarded their patients' emotional state as confidential and gave the wardens little or no support, and also towards social workers, particularly psychiatric social workers, who they felt prevailed upon the warden to accept or keep a disturbed resident and gave her an unrealistic picture of their mental state and little or no support in dealing with it. The wardens gained some relief from this ventilation of their feelings and from the shared knowledge and interchange and also from the comments of the Consultant (herself a P.S.W.) who felt that some of this hostility was related to their phantasy that she was trying to change the warden's role into that of the warden of a psychiatric after-care hostel or one for maladjusted girls. They found that in some cases a frank discussion with the patient about their tablets and sometimes to share the responsibilities for this with the patient resident by agreement, did help to lessen the danger of overdose or the patient omitting to take their drugs. They also learnt to be more confident in stating their position and views to the various psychiatric personnel.

There was some concern about residents who became obviously emotionally disturbed and were not to the warden's knowledge having medical care for their difficulties. The wardens were in some conflict about when and how to raise this with the residents and when it was appropriate to

insist on them attending the doctor or to ask them to leave the hostel. The wardens found that experience with disturbed residents gave them intuitive diagnostic pointers when they met other similar residents and the group shared and tried to conceptualise some of these feelings. This had the effect of lowering the wardens' anxieties about keeping certain disturbed residents in the group and of becoming aware when to discuss with the hostel medical adviser or other specialists certain residents who were causing them concern.

4. Crisis situations

Reactive depression in jilted residents, or those just leaving home, was common among the residents. The wardens had much unrecognised expertise in when to encourage residents to discuss a difficult problem, such as losing their job, a broken engagement or the death of a parent. These kinds of problems were discussed in the group and the wardens became less uncertain and more skilled in their ability to support and handle this kind of difficulty.

5. Testing out behaviour

It was found that many of the residents of all age groups saw the warden as an authority figure and would project on to the warden old conflicts which had their roots in unresolved childhood situations. The wardens became increasingly adept at recognising when they were being manipulated, or used in this way and learnt not to fall so easily into the trap, for example, of being set up as the interfering or disapproving mother, or the one who is not interested or does not care what the resident is doing. The wardens all had their differing standards of what they felt was acceptable behaviour and they were encouraged to express this in the group and to be aware that they too had their standards and limitations in what they could tolerate and that this was essential for the smooth running of their hostel. They also found that some residents would attempt to split their problems with authority figures between the warden and her deputy and from this knowledge became more aware of the difficult role their assistants can carry in these situations.

6. Drug addicts among residents

There was much concern about this ever increasing problem, particularly in the 'transient' hostels. By and large the wardens felt they could not

accept drug addicts because of the responsibility that this involved, although many of them would accept drug addicts for a night or two. They expressed much concern, particularly about the 'infection' of the other vulnerable residents by drug addicts and became much more expert in detecting drug addicts and arranging the room situation so that they did not come so much into contact with susceptible residents, particularly the younger ones.

7. Sexual behaviour

There was considerable discussion about what was acceptable behaviour for residents, whether men should be allowed into the rooms or sitting rooms and what was a reasonable hour for curfew. All the wardens felt that they were responsible only for maintaining minimum standards, not for the sexual behaviour of their residents, but that when flagrant sexual behaviour threatened the image of their hostel in the eyes of the community or the other residents, then it was their responsibility for the internationally accepted good name of the Y.W.C.A.

8. Pregnancies

All the wardens found that they had had girls in their hostels who became pregnant. They felt relief at learning that this was a problem which was not linked with their hostel alone.

9. Phantasies about the Y.W.C.A.

It became apparent in the group that the general public has many phantasies about the Y.W.C.A. and that these affected both the applications for residency and the attitude of the relations of residents. Some of the common phantasies were discussed by the group. It was found that middle class parents will often allow their daughters to leave home to live in a Y.W.C.A. hostel as this is felt to be a safe and acceptable halfway house between leaving home and being totally independent in the outside world. Many parents seem to regard the Y.W.C.A. as an extension of home care where their daughters would be given the individual and over-protective care such as they had been given at home. The wardens felt that the halfway house image was an acceptable one, but they were not prepared or able to give the residents the individual care which they got at home. It was found that many older women sought refuge in the Y.W.C.A. where

they felt they would not be expected to meet and fraternise with men. Several of the wardens had had experience with outraged residents when a man appeared in the hostel. Another common phantasy of the general public was that the Y.W.C.A., being a Christian organisation, would turn away nobody and would 'put up with anything'. The wardens would find, for example, that when remonstrating with a resident they would be accused by such phrases as 'call yourself a Christian', or that referring agencies would put pressure on them to take unsuitable residents by making them feel guilty and un-Christian. Some of the wardens found this quite difficult, while others felt it was not their job to proselytize Christianity amongst their residents.

The work task of the group

The work task of the group was to explore the changing role of the warden particularly in the field of human relationships, to attempt to reformulate their role and to acquire new knowledge and expertise to help them develop their skills to recognise and relate to residents with emotional difficulties. Several factors interfered or obstructed this task. Initially selected wardens were invited to attend the group and some of those invited applied. However, this was voluntary in-service training not part of their contract and it was felt that although they should be encouraged to maintain regular attendance and 'work' at the group task, wardens are busy people with great responsibilities and it was felt that absence should not be remarked on, though some of them were clearly related to individual anxieties in the wardens. The wardens were inexperienced in verbalising about their problem 'cases' and in discussing these in a group. They tended often to start discussions in pairs or sub groups excluding the rest of the group and in rivalry with the leader, or they would avoid anxiety by engaging in social chat. It was felt to be part of the learning process to help them to engage professionally in a group, and the Hostels Adviser particularly, often supported and encouraged them between meetings to bring problems to the group. The wardens' need to get together for interchange of news and social contact were partly met by monthly coffee morning meetings which the Consultant did not attend and partly by the Consultant and Hostels Adviser withdrawing after the group meeting, leaving the wardens free to chat. On one or two occasions the Consultant did have to comment to the group that they were not sharing the discussion, or that they seemed to find this particular situation difficult. These kinds of

'interpretative comments' were kept to a minimum and only made when the group learning seemed to be impeded. By the third course the wardens, who had been attending all through were quite 'professional' in the group and supported newer and more diffident or anxious wardens to participate freely. On one occasion a situation erupted in the group in which a warden was in conflict with a resident whom she wanted to leave. On another occasion a warden brought an apparently simple problem of not getting her roof repaired: when this was explored by the group, it emerged that this warden felt put on by her committee who had never really accepted that the previous warden had been asked to leave and in fact had been allowed to stay on in the hostel for months after the present warden had taken over.

This pioneer experiment is continuing and as the Consultant and the group become more familiar and gain in expertise, the work task of the group is deepening and the ability of the group to conceptualise, is improving. The groups have verbalised the support which they both gain and give one another in sharing their problems in this way and suggested that an account of their work should be given at one of the coffee meetings in the hope that this would further applications for membership.

Summary

This consultation group was set up at the request of the Young Women's Christian Association after the author had given a talk on human relationship in residential establishments. The relationship between the consultant and the senior Y.W.C.A. staff had to be clarified. The group found various problems among residents were shared by all the hostels as were common phantasies about the Y.W.C.A. The wardens felt they gained in expertise and confidence and particularly support from the group.

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Author's address: Margaret Robinson, Tutor, Advanced Casework Course, Department for Children and Parents, Tavistock Clinic, Belsize Lane, *London N. W. 3* (England).

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An Experiment in Group Training of Social Workers for Leadership of Therapeutically Oriented Groups

ILSE M. SEGLOW and H. KAYE, London

Part I

ILSE M. SEGLOW

The experiment I want to talk about had its origin in a group I initially conducted alone, and later conducted together with HAROLD KAYE. It was an interdisciplinary group, consisting of eight well-qualified and very sophisticated Social Workers of both sexes, from various fields, and of different age groups. All were interested in receiving some training as group conductors, in preparation for taking groups of their own. I should like to report on the first stage of this experiment; HAROLD KAYE will report on the second stage (Part II).

During the first four sessions, the group members almost exclusively concentrated on presenting case-material from their own experience, which indicated that initially they felt reluctant and fearful of going beyond anything but safe, objective material. As a rule they brought cases of emotionally disturbed clients towards whom they had strongly ambivalent feelings. The group usually detected this ambivalence and accused the member presenting the case of having mishandled it.

This kind of reaction repeated itself until the group was eventually able to accept and understand my interpretation: that their ambivalence was apparently a determining factor for all of them and governed their relationship both inside the group and outside in their professional life. Focusing further on this aspect, the group members came to see that many of their own previously unrecognised problems were similar to those of their clients and it emerged how often the group members tried to solve such problems by projecting their own infantile feelings on to their clients.

As the group developed further insight into their underlying feelings of hostility and guilt towards their clients, they came to understand that

these feelings were often covered up by an attitude of excessive concern and kindness. While this applied to *all* group members, they divided on certain other lines which eventually gave rise to distinctive, mutually hostile sub-groups. Among these the following were clearly discernible:

1. Those workers, the Psychiatric Social Workers, Probation Officers and Medical Social Workers who, in their opinion, had a *high* professional status compared with the workers engaged in work with the National Association for the Prevention of Cruelty to Children and with the Young Women's Christian Association, whom they considered to be of *lower* professional rank, though they had undergone the same training and were equally well qualified.

Hostility and aggressiveness during this phase concentrated mainly on devaluing these so-called lower status workers.

2. Those members who were able to 'let go' and relax found themselves in one camp, in opposition to those who tended to act out their neutrality and detachment by steadfastly controlling their thoughts and feelings and hiding behind a mask of professionalism.

3. Between the married and unmarried women, there was a rivalry in which the men acted as amused spectators only.

4. There was the tug-of-war between the older and younger group members. In fact, the two youngest members were looked upon by the group eventually as the 'naughty boy' and the 'naughty girl', particularly as these two tended occasionally to stay away from the group or come late.

5. There was an outspoken competition between men and women concerning observations and interpretations of group behaviour.

As the hostility between these sub-groups, which naturally overlapped, grew, all the members showed concern and anxiety about this hostility and became worried about revealing childish aspects of themselves. They frequently blamed themselves and the group for being infantile and unprofessional. Gradually, they became aware that they were feeling ambivalent, not only towards the group, sub-groups and their clients, but also towards themselves.

In all these currents and cross-currents of hostility I, as the conductor, was strangely enough hardly ever attacked. I remained their idealised mother-sister figure whom they somehow did not dare to damage or destroy for fear of some kind of retaliation. This changed, however, when I interpreted their attitude towards me as fear of being attacked themselves once they were leading their own groups. They agreed that if they attempted to clash with me they might destroy their source of security and thus

their ability to face up to their own groups. They thought that if they failed me, they would fail themselves. Slowly and gradually, however, the group succeeded in resolving some of its fears of retaliation from me and later risked 'dethroning' me and began to see me as a rival in leadership.

At this point I felt that possibly a somewhat unorthodox experiment might help to clarify the dependency-competitiveness climate which now dominated the group. It was tentatively suggested by me that we might try out a change-round of the conductor's role, so that each participant would be able to experience a taste of leadership before embarking on a leadership role in his own professional setting. The group seemed more than pleased with this idea – they chose as their first conductor a Probation Officer from Canada. He was a highly intelligent, competent man who, as a group member, was very active and expressed strong views on any topic which came up. He was the only one who showed some resentment against having a woman conducting the group and who manifestly and consistently tried to compete with me. This reaction, however, was only displayed by him as long as we talked about other people's – the clients – problems. When we began to touch upon personal conflicts he behaved very differently. He became hesitant, vague and dependent and everyone sensed that he felt rather uncomfortable. When the group chose him as their first new conductor, he seemed overjoyed and accepted immediately.

He came into the next session, fully prepared with a kind of agenda, all well-timed. He persuaded the group to follow this agenda, without taking much notice of what the group wanted to say. He was very authoritarian, asked questions, expected answers, interrupted when a group member said something he disagreed with, argued about a political issue, until finally the group protested and told him, in no uncertain terms, that he was abusing his role. He was hurt and taken aback. The group sensed this and suggested giving him another chance. This time he rather reluctantly accepted.

In the following session he seemed very anxious not to present the same image of himself and behaved in a rather childish, helpless way. In fact, he manoeuvered himself almost outside the group in his need to find a place of safety.

The next group conductor was a Medical Social Worker, who in the group was on the whole passive and rather listless. But, whenever she *did* say something it was always outspoken and almost explosive.

It seems conceivable that the group chose her for the next conductor

because she presented to the group the complete opposite of the first conductor. While he was outwardly aggressive and inwardly insecure, she was manifestly insecure and inwardly bursting with aggression.

As a group conductor she was more than reluctant to make any observations or interpretations. She was clearly afraid of intervening at all and exposing herself to the group. On the few occasions when she did say a word, she inevitably apologised and looked at me for help. She seemed miserable and distressed and constantly afraid of being criticised, contradicted or attacked. The group became soon aware of her discomfort and began to ignore her. The members seemed to store up their reactions until towards the end of the session when they conveyed to the group that they had felt leaderless and frustrated and that something had been 'taken away' from them. One member remarked 'deprived children must probably have similar feelings!'

Subsequently, three of the members suggested that I should again become the conductor as I was the conductor anyhow and that no other group member could replace me. Others, the majority, felt that it was a valuable experience that they should not give up. It was, therefore, decided that one of the Psychiatric Social Workers should conduct the next group, as she had to start her own group with mothers in her clinic very soon. She is a woman who at times withdrew completely from the group, at least verbally, but could, at other times, be very involved in the group proceedings and indulge in heated arguments.

She came half an hour late to our next session. The group waited for her in silence which was only occasionally interrupted by non-commital remarks. When she finally arrived, she indicated herself that her late-coming was probably connected with her anxiety of being the conductor. 'I really want to ask the group for advice about how to conduct my Mother's Group', she said, thus relinquishing the lead from the start.

The mothers she had selected for her group were all mothers of aphasic children and the group interpreted this as significant in terms of her own inability and reluctance to communicate with the group.

It soon became clear that, in this session, the group as a whole took over the lead in view of the experimental conductor's abdication. The group pointed out to her that she felt there was something 'wrong' being in a group; that she felt guilty about it, as if she were trespassing into a forbidden territory. The Psychiatric Social Worker agreed that she found the intimate, emotional climate of our group rather disturbing and could not really face up to leading a group herself.

It thus became clear that, by being projected into the new role of leader, her feelings of competence began to evaporate. She became uncertain about her own position, both in terms of her feelings towards herself as a potential group-leader and as a member of our group.

The conclusion one may draw from our experiment is, that unconscious role confusion may act as a defense-mechanism. An analogy might be the attitude of some adolescents who – on the one hand – feel often an inner need to conform increasingly to an adult behaviour pattern, whilst, on the other hand, their emotional development has not advanced sufficiently for them to fulfill such a role convincingly. This partial awareness of the causes of such a conflict only serves to intensify feelings of anxiety and insecurity. It would seem that without a very clear definition and self-understanding of role behaviour, insecurity and anxiety are an inevitable consequence.

For myself, my feelings were that I did not really manage to change from being a conductor to being a group member, and that the group somehow forced me into a double role. On the surface, I relinquished the leadership, and did not respond when challenged by the various experimental conductors to help them out. But it was a conscious effort all the time, related perhaps by all of us to the effort made in one's professional setting to be reasonable and detached. At the same time, there was a shared underlying tension in the group, a shared concern about my role and my strength. One member produced the fantasy that, dethroning me as a leader might mean annihilating their 'good mother' who would then retaliate by creating chaos and strife within the family, our group. This tension on the subsurface level was, I think, felt quite strongly by the whole group, but it had not as yet gained any meaning and coherence. However, it created a new climate of which the members were aware, and which may later be used by them as a valuable focus to explore the dependency-competitiveness situation of the group and themselves on a much deeper and more meaningful level.

Part II

H. KAYE

I joined the group in the 9th session, just before the experiment began. At the end of the first phase of this experiment, which has just been reported, it was evident that things were not living up to expectations. We had all thought of it as being a very safe situation. The group had

developed a great deal of warmth and cohesion. The members liked each other, and respected each other. Early hostilities had been well ventilated, we thought, well analysed, and worked through to a point where there was a good relationship between the members. It seemed ideally suited for the experiment, a situation that would be relatively anxiety-free for the experimental conductors. But in practice, it hadn't worked out that way. We wondered why.

We approached this problem by way of analysing the transference and especially the counter-transference. We had noted that the group had not been able to ventilate directly any negative feelings about Mrs. SEGLOW. Negative feelings toward me had come out only by displacements: they didn't like the tape recorder I had introduced, with their consent. Or they felt me as something of a threat, but couldn't say much about it. But most important was the counter-transference. Mrs. SEGLOW was aware of how much difficulty she had had in stepping down from her role as conductor. As we analysed this, it seemed clear that only part of this came out of her own difficulties. Even more of it came from the group. They just couldn't let her step down, or more accurately, be dethroned. In each of the first five experimental sessions, someone in the group made one or more efforts to re-establish her as the conductor. They would ask questions to which they often knew the answer, but which they nevertheless directed toward her: when would the next session be; had she heard from the member of the group who had left for his post abroad; was it time to begin; who should prepare notes on the session – each in turn prepared a brief report for the record.

There seemed to be a concerted effort to make sure that she was still finally in control, and that the experimental leaders were merely temporary surrogates, without power, without effectiveness – really children pretending to be Mama.

We understood this in terms of a re-experiencing of the oedipal situation. The group needed her as the focus of its dependency needs, the comforting, safe mother hen to whom the chicks would come scampering back when faced by the anxieties of becoming individuals in their own right by becoming group conductors. Dethroning her even temporarily, even symbolically, awakened their deepest fears. Symbolically speaking, it was as if they would have been killing a parent. The very fact that they had found it so difficult to talk about their feelings about the conductor, either as a role or as a person – and this was equally true of us, or of the experimental leaders – there had never to this point been any com-

ments about them either, as conductors – seemed to be a measure of their anxieties.

We interpreted this to the group, highlighting the way they avoided verbalizing negative feelings toward the conductors. There was evidence of displacement of these feelings, slips of the tongue, other evidence of turmoil in the unconscious, and we pointed out some of these. After a few moments, there came a storm of confirmatory evidence. Strong feelings of anger and hostility toward Mrs. SEGLOW began to come out. They accused her of manipulating them into the experiment, of forcing them into it for occult purposes of her own. They accused her of not being willing to give up the authority role. They said she still called the signals about when to begin, when to stop, and that whatever they pretended, she was still inevitably the final authority. A suggestion came from one member of the group; let the experimental conductor have the symbols of authority, and call the signals. In this case, the symbols included the clock by which the beginning and end of the sessions were signalled, a particular chair favoured by the therapist, and the duty of opening the door for late arrivals. It was as if the children who previously wanted to play Mother now found they needed to wear Mother's clothes to assume the role.

Mrs. SEGLOW also suggested one further change in the format: that the experimental leader conduct the first hour of the hour and a half session. I would then intervene, summarise what had been going on, interpret it a bit, and then lead on to something concerning the conductor, or to feelings about the conductor. Mrs. SEGLOW would then resume her role for the balance of the session, with me assisting.

The change in format had a dramatic effect. The next experimental conductors readily assumed the trappings of leadership, made the decisions about the beginning and the end of the sessions, and built upon this simple symbolic beginning a far more active and far more therapeutic participation than had previously been achieved. This was markedly so in the case of Mr. P., who by happy chance was both the last conductor under the old conditions, and the first under the new conditions. In his first session as conductor, he had arrived half an hour late, and at the end of the session did not know whether he had been conducting or not. The group, too, was divided about whether he had, in fact, been the conductor. It was decided to have him conduct the next session as well, so this problem could be examined and resolved.

In this changeover session, Mrs. SEGLOW felt that for the first time she had been able to relinquish her authority role without difficulty. Perhaps

because she no longer felt guilty about abdicating the role for which she had been retained by the group, perhaps because she had finally accepted her dual role and found it non-threatening, she could now participate for the first hour as a member of the group, revealing her personal feelings on occasion, and could resume her therapeutic role, with the implicit psychological distance between therapist and patient, during the last part of the session.

With the change of procedure, Mr. P. firmly took control of the situation. He had previously been seen by the group as its 'naughty boy', juvenile, mischievous, undependable. His behaviour after the procedural change and the analysis of it was mature, insightful, modelled substantially on that of the therapist.

The same high level of experimental conducting continued during the balance of the experiment, and this is particularly impressive because, as we would expect, the group selected as its first leaders the more dominant members: those who would appear to be best qualified for the role. Those left to the last were the ones who by unspoken consensus seemed least likely to succeed. Yet these were the most effective conductors of all, after the change of procedure. This suggests very strongly that the process we went through – 1. examining the transference and counter-transferences; 2. interpreting it to the group, and 3. effecting the procedural change – that this in its totality, if not in its individual parts, was the agent of change which resulted in the very impressive alteration of behaviour of the group members.

Feelings expressed within the group, even aside from those expressed toward the conductors, also developed remarkably. The group expressed feelings of intimacy, involvement, of group identity and interpersonal warmth more freely and in greater degree than ever before. But these warm feelings did not prevent the group from examining, analysing, and attacking with considerable vehemence the behaviour of its most resistant member, who had consistently tried to intellectualise the whole group experience, to deny her own hostile and aggressive feelings, and to try to prevent others from expressing their own negative feelings. Thus, a broad spectrum of feelings was liberated, from very loving to very angry ones, and the group was able to contain, accept, and work with these feelings with notable satisfaction.

Changes in behaviour also came at an increasing pace during the second phase of the experiment. Naturally, these would occur anyhow towards the termination of any closed group, and they might well have

occurred independently of this experiment. But it is difficult for us to believe that the experiment, which was so significant an event in the life of the group, did not also play a significant part in the changes.

A basic conclusion emerges from a consideration of this experiment. We need to ask some serious questions about the whole idea of role-playing, as it is used in student training with young doctors on ward rounds, and I've heard these described as an exercise in humiliation, with young lawyers in moot courts, with student teachers in some practice teaching situations. With young executives, or young salesmen. Is role playing of this sort altogether what it seems, or does it release, as it has in this experiment, factors and affects unanticipated in the original experimental design? We need to ask serious questions about this, and to look closely at what happens. The evaluation of the psychological factors released as totally unsuspected concomitants of the training situation are worthy of close investigation and analysis.

Ventilation of feelings – toward the authority figures who teach them as well as toward their fellow students – may be a useful liberator. The use of symbols of authority may well be of value in making these procedures more productive, more what they are meant to be. In any event, it would seem clear that it would be useful to question many of the concepts of role-playing, and to see whether they are indeed what they seem, what they want to be, and what they most usefully can be. This experiment tells us that it is much too easy to take for granted things which need to be questioned, and questioned repeatedly and consistently.

Summary

After nine sessions of a closed training group of eight social workers, it was decided experimentally to rotate leadership between the several members during the remaining sessions. It was anticipated that this would give each member practical experience in group leadership under conditions of minimum tension. Instead, intense anxiety arose, as Oedipus-like conflicts were reawakened, with the implicit dethronement, and thus killing, of the regular group conductor. Methods to counteract this via transfer of symbols of leadership were developed, and the differences of behaviour before and after the symbolic change are reported and discussed. Application of the findings to training of teachers, doctors and lawyers are discussed, and cautions concerning implications of role-playing techniques are offered.

Author's addresses: Dr. I. SEGLOW, 192 Goldhurst Terrace, *London N.W.6* and Dr. H. KAYE, 57 Albert Hall Mansions, *London S.W. 7* (England).

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Drug Addicts in a Therapeutic Community

Outline on the California Rehabilitation Center Program, Corona

V. S. FISCHMANN, Corona, Cal.

> *Motto:* It is the intent of the legislature that persons addicted to narcotics, or who by reason of repeated use of narcotics are in imminent danger of becoming addicted, shall be treated for such condition and its underlying causes, and that such treatment shall be carried out for nonpunitive purposes ... The principle purpose of the California Rehabilitation Center shall be the receiving, control, confinement, employment, education, treatment and rehabilitation ... [California Welfare and Institutional Code, 1965].

Definition of the problem

Understanding and treatment of a phenomenon which has complex medical, psychological and sociological concomitants is necessarily an interdisciplinary enterprise. But regardless of specialization, theoretical framework, or social philosophy, the general consensus is to view narcotic addiction as a form of deviant behavior.

This form of deviant behavior has not responded to traditional psychotherapeutic and rehabilitation approaches [BRILL, 1960]. This is to say the problem is not to *get* the addict off drugs but to *keep* him off when he is not under close institutional or other supervision.

Let's consider the following situation: a typical narcotic addict is committed to the drug-free environment of the California Rehabilitation Center (CRC) after he went through the withdrawal reaction. He stays there for many months without showing any physical symptoms, and for all practical purposes is not any more physically dependent on drugs. The following question seems to be justified: is he still, strictly speaking, a narcotic addict? Of the three criteria of narcotic addiction: tolerance, physical dependence, psychic habituation (World Health Organisation – definition, 1950), only the last characteristic is still present.

It follows that a lasting cure and rehabilitation of the narcotic addict depends on a successful treatment of his psychic dependency on the drug. Thus, the problem this report is dealing with concerns the overpowering need of the narcotic addict to revert to the use of the drug, and the treatment modalities employed by CRC in order to free him from this dependency.

Terminology

Medically, narcotics are drugs which are sleep-inducing, particularly opiates and synthetic analgesics. In the United States, however, by legal provision and often by general usage, 'narcotics' refers to various kinds of drugs, including some which have stimulating effects and/or do not produce physical dependence. For instance, the California Narcotic Act includes among 'narcotics' cocaine and marijuana.

This lack of terminological precision has little practical significance, since of the approximately 2,000 addicts in CRC almost 93 % were primarily heroin users. In this paper I am using the legal definition because we have found more similarity than difference between opiate abusers and abusers of other drugs.

Characteristics of the CRC population

The general character of narcotic addiction in the USA was described elsewhere [HARNEY, 1962]. Of the two principal types – 'professional group' and 'delinquent group', the California Rehabilitation Center deals almost exclusively with the second.

Characteristics of 1231 new admissions to the CRC (January – December, 1966):

Sex:	Males exceed females 7 to 1.
Age:	Young group. Median age 27 or 7.5 % (92) under 21.
Race:	Minorities predominate: 45 % (547) of European descent, 37 % (459) of Mexican descent, 17 % (212) Negro, others 1 % (13).
Class:	Low socio-economic background. Unskilled and semi-skilled labor in majority of cases.
Parents:	The great majority of addicts come from broken or incomplete homes.
Intelligence:	Slightly above that of general population. Most fall in the 'normal' and 'high average' range.
Education:	Median grade level 8.8. Only 25 % (300) have a school grade placement of 9.5 or better.
Drug History:	The great majority experimented with marijuana in their teens. Intravenous use of heroin began at about 20 years of age.
Criminal history:	The great majority has a history of juvenile and/or adult arrests. But 82 % (1009) have no prior felony (prison) commitment in their record.
Differential diagnosis:	According to the classification of the American Psychiatric Association, 'Drug addiction is usually symptomatic of personality disorders'. This is true of about 80 % of addicts at CRC. A smaller segment can be described as primarily 'neurotic'. Perhaps 5 % turn out to be latent or borderline schizophrenics. The majority of 'character disorders' show mixed traits. Features of inadequate, passive-aggressive, unstable and sociopathic (dyssocial) personality are the most frequent.

Structure and goals of the program

Addicts are civilly committed by the Superior Court, not sentenced. The term of commitment is seven years for most cases. The first six months must be spent in the institution. During their institutional period, committed addicts are called 'residents'. The former addict may then be placed on parole. This second phase of the program is called 'Outpatient Status' (OPS). Violation of the OPS is usually followed by return to the institution for additional treatment. Drug use is the most common violation leading to return to CRC; however, OPS may be suspended for violation of any one of 13 conditions, including arrests for criminal acts, absconding from supervision, poor adjustment, changing jobs without permission, abusing alcohol, etc. If a person remains in all these aspects clean for three consecutive years, he is discharged from his civil commitment.

The emphasis within the institution is upon the group or community living. The basic treatment units are dormitories of 50 women or 60 men where formal group sessions are held for at least one hour five days a week.

As an adjunct to each dormitory centered program there are medical, psychiatric and psychological services; academic and vocational schooling; work assignment; religious services; family counseling; libraries, sports, special small treatment groups, Narcotics Anonymous, etc.

It is then important to keep in mind that the California rehabilitation program for narcotic addicts has two phases: the inpatient program which combines control (forced abstinence) with treatment, and the outpatient program which consists mainly of control (nalline tests, urinalysis, regular supervision by field agents). Also, the objectives of the California program are not limited to inducing persistent abstinence but include bringing about personality changes conducive to better functioning in the different areas of social life.

The twofold goals of the inpatient program, confinement and control in order to protect society from law breakers, and therapy and rehabilitation in order to reintegrate law breakers into society, are reflected in a more or less pronounced dichotomy of roles, functions and attitudes of the institutional staff. Though much effort is directed toward uniting the custodial and treatment personnel into harmonious work teams, the first continues to represent the traditional authoritarian point of view of corrections, while the second tends to be permissive and not strongly value oriented.

Therapy is directed and supervised by Correctional Counselors who together with Correctional Officiers (custody) are responsible for the dormitory communities. A typical counselor has a B.A. and two years of general experience in some areas of social sciences. He leads the daily group sessions, determines specific treatment goals of his residents and evaluates their progress and suitability for OPS. It is likely he became clinically familiarized with drug addicts and acquainted with other types of psychopathology only after coming to CRC, but he has the opportunity to participate in the institutional in-service training and also seek professional advice from psychiatric services. The small staff of psychologists and psychiatrists functions as consultants. At CRC, psychologists and psychiatrists are excluded from direct participation in the treatment program, so that the complex and difficult task to achieve personality and behavior changes in drug addicts is primarily dealt with by Correctional Counselors.

Treatment rationale

The surest way to make people abstain from narcotics is to make narcotics unavailable to them. This, in a free and open society is practically impossible to achieve.

The other potentially 'sure' approach would be through the use of chemical antagonists. This pharmacological method, however, is still in the preliminary stages of experimentation and, therefore, not applicable at the present time. The so-called 'maintenance therapy' in which opiates are supplied to the addict under careful supervision is prohibited by law in California.

Voluntary hospitalization has proven unsuccessful. Once detoxified the majority of patients revert to the abuse of drugs. Furthermore, addicts of the 'delinquent' type don't consider themselves sick and don't make any real effort to be treated, rehabilitated, cured.

In the United States there are several private organizations of the 'spiritual-religious' type dedicated to treatment of narcotic addicts. Such groups as Synanon, Teen Challenge, N.A., etc., developed special techniques which seem successful with those of the addicts who are able to accept the esoteric philosophy and way of life of these organizations. It is unlikely that they will ever reach the majority of the addict population.

According to the California Citizen's Advisory Committee report to the Attorney General, in 1954, there were in California close to 20,000 illicit addicts [ELDRIDGE, 1962] most of whom obtained narcotics illegally. From July 1, 1959 through December 31, 1965, a total of 19,892 addict-users had been reported[1]. The severity of this social problem required radical remedial action on the part of society and explains the need for the establishment of a compulsory institutional rehabilitation program.

Two further considerations will clarify why the treatment rationale of this program had tried to follow the guide-lines and principles of the 'therapeutic community'. First, a simple incarceration in a correctional institution tends to create conditions which have traditionally characterized the punitively oriented atmosphere of a prison. These conditions are undesirable for several reasons; it is unfair to imprison a person whose primary problem is a compulsive, self-destructive behavior; traditional prison methods tend to reinforce the inmate's ties to the delinquent culture which, in case of the sociopathic addict, has been etiologically significant in

[1] Bureau of Criminal Statistics in the State Department of Justice, Sacramento, California 1965.

the creation and continuation of his habit; it does not work well as a deterrent in preventing return to drug abuse, because between immediate pleasure gratification and the threat of future punishment the typical addict will choose the first alternative; finally – and this might well be the most important reason why drug addiction has not responded to traditional punitive approaches, addicts (and other law violators) usually function better in the structured environment of a prison than when facing the stresses of 'free life'. The point is that for many addicts arrest and imprisonment reinforce their tendency to avoid responsibilities, similarly as the narcotic 'crutch' does.

Theoretically, the dilemma embodied in the 'hospital prison' arrangement can be solved [THORPE, 1956]. If the traditional, structural and functional system of a prison is adapted to that of a therapeutic community, the right therapeutic climate is obtained and none of the necessary controls are relinquished.

The second consideration concerns traditional analytic psychotherapy. Theoretical reasons and clinical experience support the view that classical reconstructive therapy, applied individually or in groups, is quite inefficient with most of the addicts of the 'delinquent type'. SCHULMAN [1956] points to the difficulties which are encountered when the principles of free association, transference, catharsis, insight, etc., are used in the treatment of alloplastic symptom formations. Others think that 'considerable departure from the classical paradigm are required for the management of character disorders . . . addictions . . .' [BERNSTEIN, 1965, p. 1177].

We are inclined to go further. Our personal experience with many of the psychotherapies of the interpretative type agrees with reports of other therapists in the field. Regardless of individual or group setting and also of the syndrom in question, interpretative psychotherapy requires, in order to be meaningful, a certain degree of cultural and intellectual sophistication, and an attitudinal set which is produced by identification with the middle class value system [BRICE and STORROW, 1960; STORROW, 1962].

A poorly motivated, uneducated, action oriented, addict-delinquent from a low or marginal sub-group is rarely able and willing to engage in a long-term introspective analysis of his past and present 'Erlebnismaterial'.

It is our contention that the above difficulties are a natural outgrowth of the classic medical and psychoanalytic treatment model applied to a situation where the dichotomous 'doctor-patient' relationship makes little sense. Such a relationship presupposes common language and common goals. Where these are weak or missing, as by definition and fact is the

case when the therapist confronts alloplastic behavior formations, another model is needed in order to establish the desired therapeutic situation.

Two practical problems are here involved. The first deals with the question: How can the addict-delinquent be reached by the therapist? This is answered by referring to the addict's responsiveness to his peer group of other addicts. Accordingly, the theory calls for a close association of the therapist with the group (e.g., dormitory community) in order to therapeutically influence the subject through and via the group. This in principle is possible to achieve because social pressure as experienced in a group does bring about modifications in personality and behavior even though the individual often remains unaware of the mechanism involved. Nor is it a contradiction to expect that under certain conditions a group of drug addicts could exercise a beneficial influence upon its own members. DURKHEIM and a host of modern sociologists and social psychologists described the functional priority of the group, in the sense that an organized social system develops its own characteristic culture which tends to be self-perpetuing, is relatively unaffected by the coming and going of individual members, and even differs from the sets and patterns characterizing individual members prior to their integration in the system.

The second practical problem concerns the question: How can the therapist reach and influence a group of addicts-delinquents, in order to convert it into the desired therapeutic tool? The author of the 'Therapeutic Community' [JONES, 1953] and other [WILMER, 1962] agree that '. . . . perhaps the most important single factor in the establishment of a therapeutic climate is the personality of the leader' [JONES, 1962]. It is then necessary that the therapist adds a new dimension to his traditional role: that of the leader of the group. In this he should be assisted and supported by other staff members of the institution, because the whole time spent in the institution should be treatment, and because therapy should include all addict's contacts with other people. Nevertheless, the main burden rests on the shoulders of the therapist-leader.

The theory of group leadership and the need to distinguish leadership from domination or headship have been discussed elsewhere [e.g., GIBB, 1954]. This theory must be incorporated into our model, if effective behavior change of the addict, by the therapist, via the group, is to be achieved. The dilemma here encountered is similar to that of the 'hospital-prison' arrangement. The therapist is a staff member of the correctional institution and represents society and law which have committed the addict to the institution for control and treatment. At the same time he is supposed to

identify with the inmates in order to be accepted by them *qua* member-leader of their group. This dual role can be reconciled by subtle psychological manipulation requiring expert psychological training, rich experience, and special personality on the part of the therapist. Experience has shown that without these qualities the would-be therapist-leader will not succeed in bridging the 'we inmates – they staff' gap generated by the prison system nor will he be able to transform the atmosphere of delinquent game-playing into a therapeutic group culture, as postulated by the program.

This brings us to the final comment on the treatment rationale in discussion. JONES' basic dictum that 'a healthy group-life would make healthy individuals' [JONES, 1953] offers few concrete formulas for converting the theoretical model into working reality. This is only natural if we consider that from the medical-psychological point of view concepts like 'healthy group-life' or 'therapeutic community' are formal postulates with strong ideological-cultural references. For this reason, and also because of specific locally conditioned influences of organizational and personnel nature, JONES' classic experiment at the Belmont Hospital in England underwent extensive modifications by being transplanted to a correctional institution in California.

The CRC group treatment concentrates on problem areas of the addict which is believed, are the underlying causes of his escape into narcotics, e. g.: feeling of inadequacy, low self-esteem, passive-aggressive defenses, instability and impulsivity, authority problem, and dyssocial identification. The practice is to discuss and analyse these problems in order to promote insight and self-awareness, but behavior therapy and social learning are stressed as well as psychodynamics. The daily examination of behavior and current problems, feed-back to the peer group, handling of interpersonal conflicts and transgressions by the group, and other techniques suggested by JONES and his followers also are accepted and implemented.

Nevertheless, the ideological, cultural and local references of the CRC program become evident when the concrete substance of its psychology is examined. This is particularly true in respect to prevailing attitudes toward discipline, authority, individualism, introversive orientation, transubjective values, and systematic *'Weltanschauungen'* of the European type. Though it is unlikely that any society confronting deviant behavior could successfully impose conformity with its cherished values by means of scientific psychology alone, modern progress of behavioral sciences warrents maximum implimentation of their findings.

Results

CRC has been operating since 1961. The average addict spends about 10–12 months in the institution. Therefore, it would have been possible for the first group to complete successfully the three years of outpatient status (OPS) only within the last 2 years. About 16 % (74) of this first group of 454 addicts (June 1962–June 1963) have been successful and released from the program.

Status one year after release to OPS from CRC (1207 released, June 1962–June 1964): 35 % (419) still an OPS; 18 % (203) suspended but not returned to CRC; 47 % (572) suspended and returned.

Weeks on OPS one year after the first release (1962-64 releases): Average of 30.8 weeks on OPS following first release. As the number of weeks on OPS increases, the % who fail OPS decreases.

Types of new convictions (1962–64 releases): 77 % (914) no new convictions; 18 % (214) misdemeanors; 5 % (66) new felonies.

Illegal use of drugs (1962–64 releases): 55 % (660) of men and women released to OPS were detected as having illegally used narcotics.

Though it is difficult, if not impossible, to compare these results with other follow-up studies, because each uses different criteria, we believe that the pioneering program of CRC has met with moderate success in handling the difficult problem of narcotic addiction.

Summary

Rehabilitation of the narcotic addict based on civil commitment to in-patient treatment preliminary to a closely supervised after-care program is being carried on at the California Rehabilitation Center with encouraging results. This pioneering program provides for school education, vocational training, work assignment, group counseling and group therapy within the setting of a correctional institution.

The difficulties inherent in the attempt to create the right therapeutic climate in a prison are discussed and analyzed.

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Versuch einer Grossfamilie

Die «Family by choice» als Mittel zur Rehabilitierung des Menschlichen

CATHERINE K.-GINSBERG, Kew, Surrey

Eine der wichtigen Fragen, die bei der Erforschung von Vorbeugung und Rehabilitierung, den Themen dieses Kongresses, leicht übersehen wird, scheint mir die Frage nach der Zielsetzung: wogegen wollen wir vorbeugen, und wohin und wofür sollen wir helfen zu rehabilitieren?

In unserer Welt der auf- und umbrechenden Familie und Gesellschaft werden alle menschlichen Grundprinzipien, politische, religiöse, moralische, neu in Frage gestellt. Entweder versteinern die alten Prinzipien und werden, um sich zu erhalten, zunehmend autoritär, oder sie müssen neu überdacht bzw. verändert werden. Aus der Unsicherheit und Entleerung von menschlichen Werten und Beziehungen suchen revolutionierende Kräfte nach Auswegen, nach neuer Freiheit in rationaler und irrationaler Weise.

Auf der einen Seite finden wir die politische oder unpolitische Rebellion der Jugend, auf der anderen Seite Verwahrlosung und geistige Erkrankung, die den Eindruck erwecken, als wären sie ein Protest gegen die in Erscheinung tretende Sinnlosigkeit einer mechanisierten Gesellschaft.

Die Zunahme der Verwahrlosung und der geistigen Erkrankung erscheint wie ein grosses Fragen nach dem gegenwärtigen Wert und der Zielsetzung unserer Gesellschaft. Der Grundstock des Staates, die Familie: ist sie noch ein lebendiger Wert, oder ist sie nicht meistens nur noch eine Institution, aus der die Jugend so schnell wie möglich ausbricht?

Die Diagnose und Deutung der verschiedenen geistigen Erkrankungsformen bei Individuen war und ist eine der Zeit entsprechende, notwendige und heilbringende Aufgabe der Forschung. Sie hat zusätzlich zur Auffindung der Krankheitsherde in der Familie geführt und damit den sozialen Aspekt gezeigt.

Wenn heute die psychischen Erkrankungen in einem solchen Masse anwachsen, dass Anstalten, so gross wie Städte, für sie gebaut werden müssen (in Amerika, zum Beispiel, mit 3500 «Einwohnern»), so zeigt dies in erschreckender Weise das Ausmass des Protestes, der unbewussten inneren Auflehnung.

Sind die Präventivmassnahmen weiterhin auf das einzelne Individuum abzustimmen? Deutet, was im einzelnen als «Symptom» gefunden wurde, auf die Erkrankung der Gesellschaft hin?

Die Beatniks, die Provos, die Hippies, die Süchtigen: stellen sie nicht mehr oder weniger rebellierende Warnzeichen für ein Versagen unserer Gesellschaft dar? Und nicht nur auf ein Land beschränkt, sind sie zu internationalen Phänomenen geworden.

Haben diese rebellierenden Kräfte einen gemeinsamen Nenner? Ist die Welt, zu der die Hippies «nein» sagen, und in der die geistige Erkrankung eigene «Lebenswege» sucht, zu eng, zu unwirklich, zu einsam geworden, trotz aller technischen und materiellen Erweiterung?

Überall, in den verschiedenen jugendlichen Protestkundgebungen, wie in der psychischen Erkrankung, finden wir die Suche nach einem verlorenen Wert, nach menschlicher Beziehung, nach menschlicher Gemeinschaft. Wo sind diese Werte heute noch zu finden, wo sind sie lebendig? Vor dem Radio, vor dem Fernseher, in der sogenannten Geselligkeit, in der Arbeit, in der Familie?

Das Bedürfnis nach neuer Lebensform zeigt sich heute in der zunehmenden Zahl von verschiedenartigen Gemeinschaftsbildungen. Sie alle gruppieren sich um ein spezielles Anliegen, das sie gleichzeitig wesentlich von einander *unterscheidet*, z. B. der Kibbuz, die religiöse Gemeinschaft, die freie Universität, die therapeutische Gemeinschaft, die Hippie-Gemeinschaften wie die «Diggers». Alle diese verschiedenen Gruppen haben aber eines *gemeinsam:* den mitunter diffusen Wunsch und die Suche nach menschlicher Beziehung.

Als Beispiel einer Realisierung dieses Wunsches nach Gemeinsamkeit möchte ich nun über den Versuch einer neuen Gemeinschaftsbildung sprechen. Sie ist eine «Gross-Familie», die sich «Family by Choice» nennt. Sie wurzelt in den Werten von Offenheit, Zugehörigkeit und Freundschaft, und der materielle Aspekt steht nicht im Vordergrund. Der Versuch zu diesem Experiment wurde zu einer Zeit (Anfang der 50er Jahre) unternommen, in der die Welt noch die Kriegswunden heilte, und es so schien, als ob in diesem Heilungsprozess auch die Kräfte zur Gemeinsamkeit wirksam wären.

Zu eben dieser Zeit arbeitete ich in einer Privatklinik in London als Psychotherapeutin und sah damals schon in den verschiedenen Krankheitssymptomen einen gemeinsamen Nenner: Familienverlust und tiefe Vereinsamung. Die Kranken, die in dieser Klinik wohnten und in psychotherapeutischer Behandlung standen, erfuhren zusätzlich einen befreienden und heilenden Ausweg darin, dass sie sich zu einer Gruppe zusammenfanden. Diese blieb aber ohne Struktur und ohne Zukunftsbild. Drei Jahre lang beobachtete ich diese immer wechselnde Gruppenbildung. Dabei wuchs in mir die Idee und der Wunsch, eine strukturierte Gemeinschaftsbildung zu wagen, die von den potentiellen Mitgliedern in Verantwortung gewählt würde. Diese sollte, so hoffte ich, den Charakter einer neuen Art von Familie haben, einer «Wahl-Familie», um so vielleicht dem Familienverlust, der Vereinsamung, der Beziehungslosigkeit zu begegnen.

Ich unterbreitete diese Idee neun Analysanden, die erfolgreich aus der Behandlung entlassen worden waren. Sie waren neugierig und willig, ein solches Experiment zu wagen. Sie alle waren «rehabilitiert» im geläufigen Sinne. In Wirklichkeit aber liess sich ihre Lebenseinstellung folgendermassen umschreiben: Sie steckten in dem Panzer jener bürgerlichen Gesellschaft, in der «Haben» grösser geschrieben wird als «Sein». In ihren Wünschen erschien ihnen alles hell und voller Gemeinsamkeit, und die Liebe schien flüssig zu sein. Das Wort «wir» machte sie fröhlich und wurde zum Ansporn. Im Gespräch um die Zukunft war alles Fremde, auch die Teilung, aufgehoben. Es schien wie eine Befreiung zum Leben.

Aber mit der *Verwirklichung* von Gespräch und Theorie, mit dem Eintritt der *Wirklichkeit* von Haus, Plan und Ordnung, begannen die Probleme des Zusammenlebens sich zu zeigen. Das wirkliche Erleben und die wirkliche Begegnung waren nicht immer hell und nicht immer fröhlich.

Ich schildere dies, um den Unterschied aufzuzeigen zu den vielen gewollten und ersehnten Gemeinschaften, die daran scheitern, dass sie am Ende den Zusammenprall von Wunsch und Wirklichkeit nicht ertragen können.

Wir begannen mit dem Gemeinschaftsversuch, der «Family by Choice», vor 15 Jahren, ohne Vorbild, unter ungünstigen räumlichen Bedingungen (das Haus wurde von offizieller Seite zur Verfügung gestellt, da ich zu der Zeit die nötigen Mittel nicht besass). Die Miete war hoch, der Komfort gering, wir hatten keinerlei materielle Vorteile von diesem Hause. Und dennoch, und vielleicht gerade deshalb, wurde es das Mittel zu unseren ersten, wesentlichen Erfahrungen.

Welches waren die ersten Erfahrungen? Wir hatten dieses Gemeinschaftshaus. War es aber anders als die vielen Gemeinschaftshäuser, in denen Menschen in Einsamkeit zusammen leben, ohne sich je zu treffen oder zu kennen? Wollten wir die Gemeinschaft, so mussten wir sie erst schaffen.

Fangen wir mit einem praktischen Beispiel an: es gab gemeinsame Küchen. Hier zeigten sich die ersten Schwierigkeiten, denn es gab keine institutionelle Autorität, die ansagte, was man zu kaufen oder zu kochen hätte, und wessen Geschirr oder Besteck zu benutzen sei. Infolgedessen mussten die Frauen ihre persönlichen Geschmacks- und Besitzansprüche aneinander anpassen. Hier entstanden langsam, unter Schwierigkeiten und doch wie aus sich selbst heraus, Gespräch und gemeinsame Beratung, und daraus allmählich gemeinsamer Besitz. Dies ist ein Beispiel für viele spätere Probleme, wie z. B. Wohnraumeinteilung, Tischgemeinschaft, Kindergärten, gemeinsamer Schulbesuch.

Über die praktischen Fragen hinaus waren jedoch die wesentlichen Probleme von wirklicher Begegnung und innerem Kontakt zu lösen. Die in immer neuer Form erscheinende Grundfrage war: Wo trennt sich das individuelle vom gemeinsamen Leben?

Um der Vielfalt dieser Probleme zu begegnen, führte ich die regelmässige Gruppentherapie ein. Sie wurde der «königliche Weg» aus der isolierenden Vereinzelung zur Durchbrechung emotioneller und intellektueller Hindernisse. Sie half aus der Blindheit von Angst und Hass, von Mangel an Vertrauen, von unbewussten Motiven und Handlungen zum Sehen und Verstehen von sich selbst und den anderen. Sie baute immer wieder die so verletzliche Brücke zwischen dem Ich und dem Du, zwischen dem Ich und dem Wir. Diese Gruppentherapie war und blieb durch die vielen Phasen unserer Entwicklung das Hauptmittel, das zu vertieftem Verständnis, zur Freundschaftsmöglichkeit, zur Erhaltung der Ehen und des individuellen Familienlebens innerhalb der Gemeinschaft beitrug. Sie führte von der Beurteilung und Verurteilung zum Einsehen, zur Einsicht, und heilte die Entfremdung. Selbst bei unseren Kindern haben Kindergruppen zum Verständnis von zuzeiten schwierigen Kindern geführt und erneute Freundschaftsbildungen ermöglicht.

Auch unsere praktischen Fragen haben wir immer vorerst als psychologische Probleme betrachtet. Sind diese von falschen emotionellen Motiven, von Egozentrik befreit, so ist es erstaunlich leicht, sie sachgemäss zu beantworten.

Andere Mittel zur Lebendigerhaltung von innerem und äusserem Kon-

takt waren und blieben das gemeinsame Leben, Gespräche, Musik, aber auch das Feiern von Festen. Am Anfang waren die Feste Feinde. Geburtstage, besonders die eigenen, wollte man am liebsten vergessen. Sogar als der Widerstand überwunden war, fehlte zunächst die Fähigkeit zur Freude. Heute jedoch – ein Zeichen unserer Entwicklung – kann die kleinste Gelegenheit ohne grosse Vorbereitungen zu einem wirklichen Fest werden.

Bis zu diesem «Heute» war es aber ein langer Weg – 15 Jahre, die persönliche, professionelle und räumliche Veränderung brachten, in einem Auf und Ab von zunehmender Gesundung oder zeitweiliger Rückfälligkeit. Diese Jahre brachten auch numerischen Zuwachs. Wir sind jetzt 65 Menschen, darunter 32 Kinder, und leben in unseren eigenen Häusern.

Wer sind wir? Wer waren wir? Wie leben wir?

Die Erwachsenen unterscheiden sich beruflich, einkommensmässig, in Religion, Alter, Herkunft und Gesundheit. Die meisten bilden Familien, einige sind unverheiratet, darunter Geschiedene und ein Witwer.

Die Mitglieder der «Family by Choice» sind mehr oder weniger religiös «gestimmt». Dieses grundlegende Element wird zur bindenden Erfahrung: es erlaubt dem anderen die Zugehörigkeit zu seiner Konfession, welche diese auch immer ist. (Wir haben Christen der verschiedenen Bekenntnisse, wie auch Juden.)

Die Berufe zeigen eine grosse Variationsbreite. Es gibt künstlerische Berufe (drei Architekten, zwei Maler, ein Dichter, ein Schriftsteller, ein Schauspieler, ein Musiker, ein Töpfer, ein Sänger); akademische (Lehrer und Dozenten in Mathematik, Geographie, Psychologie, Dramatik sowie Bibliothekare); technische (Chemiker, Ingenieure); kaufmännische (ein Verleger, ein Verkaufsdirektor, ein Personalchef), und ein Mitglied ist im diplomatischen Dienst.

Schon durch diese Vielfalt der Berufe entsteht ein bereichernder Austausch von Erfahrung und Wissen ohne den heute üblichen Wettbewerb.

Die Mütter (und das sind fast alle) haben ihre früheren Berufe freiwillig aufgegeben aus der fast unmodernen, aber lebendigen Erkenntnis der Bedeutung des Mutterseins. Sie fühlen sich nicht deklassiert durch den Berufsverlust und beneiden auch nicht den arbeitenden Mann. Ihre Absicht ist es, vielleicht nachdem die Kinder herangewachsen sind, in ihren Beruf zurückzukehren, oder einen anderen zu wählen.

Die schulreifen Kinder gehen in die gleiche, von uns gewählte Schule, die jüngeren werden am Vormittag im Haus von den Müttern in drei Kindergärten betreut. Diese Kinder haben dann eine gemeinsame Mahlzeit,

nach ihnen die Mütter. Die Schulkinder treffen sich nach der Schule im Spielzimmer, wo die bekannte «Nach-Schul-Unruhe» in kreativer Tätigkeit (in Drama, Musik und Malen) aufgefangen wird. Auch in den Ferien werden die Schulkinder am Vormittag in einer Spielgruppe zusammengefasst, so dass auch die Ferienzeit ihre Struktur bekommt.

Die Aussage des Schuldirektors über diese Kinder ist vielleicht illustrierend. Obgleich seine Schule unter Mangel an Plätzen leidet, hat er sich bereit erklärt, alle unsere Kinder aufzunehmen, weil er sie, wie er sagte, «wie einen frischen Wind empfindet, trotz dem Unterschied ihrer Begabungen».

Was waren wir? Zur Zeit, als die Mitglieder der «Family by Choice» in die Einzeltherapie kamen, waren sie krank, berufs- und beziehungsunfähig. Die Skala der psychischen Störungen war weit. Sie zeigte eine grosse Verschiedenheit sowohl in der Intensität, wie auch in der Art der Symptomatik. Es gab unter ihnen Verwahrloste, Angst- und Zwangsneurotiker, Hysteriker, Depressive mit Selbstmordtendenzen, Schizophrene, eine Konzentrationslagergeschädigte, ein Patient mit Chorea Huntington. Einige von ihnen waren vorher zum Teil über längere Zeit hospitalisiert. Sie hatten jede Art von physischer Behandlung erhalten: Drogen, Schocktherapie, und einer von ihnen eine doppelseitige Leukotomie.

Als diese Störungen sich in der Therapie besserten oder verloren, und die Analysanden nun berufs- und beziehungsfähig wurden, stellte sich die Frage, ob sie in ihre frühere Umgebung «zurückzurehabilitieren» seien, oder ob sie es vorziehen würden, in einer neuen Umgebung zu leben, die ihnen die Möglichkeit gäbe, ihre neu gefundenen Kräfte zu aktivieren. *Die Entstehung der «Family by Choice» ist die Antwort von 33 Menschen auf diese Frage.*

Wie leben wir? Wir leben in sieben Häusern, die einen Komplex bilden, und in diesem Komplex leben wir in sieben «Units» (Einheiten). Jede «Unit» besteht aus mindestens 2 Familien und einigen Unverheirateten. Die Unverheirateten haben ihre eigenen Zimmer. Jede Familie hat ihre eigene Privatwohnung innerhalb einer solchen «Unit», aber ohne eigene Küche. Die Aufteilung in «Units» hat den Sinn, verschiedene Familien in einer gemeinsamen Küche um *einen* Esstisch zu vereinen, die Anzahl aber klein genug zu halten, dass Kontakt und Gespräch möglich bleiben.

Unser Leben ist in allem zugleich gemeinsam und privat. Die Privatsphäre ist, trotz aller Gemeinsamkeit, durchaus geschützt: als indviduelles Familienleben, als Arbeit, als Raum und auch als Besitz.

Wir haben gemeinsame Räume (Gemeinschaftsräume, Küchen, Gastzimmer, Garten), aber auch unsere privaten Räume. Alles, was den gemeinsamen Raum ausmacht, ist gemeinsamer Besitz. Alles, was die privaten Räume bestimmt, ist privater Besitz. Wir haben gemeinsame Ausgaben (Miete, Haushalt, Empfang gemeinsamer Gäste) und private Ausgaben (alles vom Kleid bis zum Auto). Die privaten Einkommen sind verschieden, ohne dass dies eine Trennung bedeutet. Zum Beispiel wurde der Anspruch auf Raum des Einzelnen oder der individuellen Familie stets durch *Ein-sicht* und nicht durch *Ein-kommen* entschieden.

Die materiellen Mittel zum Aufbau wurden von uns selbst aufgebracht, und zwar durch berufliche Einkommen, und nicht aus Vermögens- oder anderen Hilfsquellen. Ich möchte hier noch einmal betonen, dass materielle Vorteile in der Gemeinschaftsbildung niemals eine Rolle gespielt haben.

Eine Ausbreitung unserer Gemeinschaftsidee hat sich in den letzten Jahren ohne unser Zutun von selbst ergeben. Analysanden, meine eigenen und die meines Kollegen, die in der Einzel- und Gruppentherapie standen und stehen, haben sich in unserer Nähe in 6 Häusern und 2 Wohnungen angesiedelt. Wieder sind es verheiratete und unverheiratete, insgesamt 31 Personen, davon 11 Kinder. Die Hälfte von ihnen lebt auch schon in kleineren «Units» zusammen, und alle bilden untereinander einen eigenen Freundschaftskreis.

Wir sind im Begriff, zwei weitere Häuser zu erwerben, in denen nun die älteren Angehörigen der «Family by Choice» ihr eigenes Leben leben werden. Diese Blutsverwandten standen unserem Experiment anfangs feindlich gegenüber, aber jetzt beweisen sie ihre Wandlung damit, dass sie in unserer Nähe leben möchten.

In 15 Jahren entwickelten wir unsere heutige Lebensform individuell und gemeinsam. Das bedeutet nicht, dass wir uns von der Aussenwelt abgeschlossen haben. Wir haben zahlreiche Gäste, und oft für lange Zeit kranke Gäste. Wir zogen uns nicht von Krankheit und Tod zurück. Die zunehmende Unruhe in der Welt führt uns jetzt dazu, uns als Gemeinschaft auch mit den Tagesereignissen auseinanderzusetzen.

In diesem Beitrag habe ich nur Rahmen, Sinn, Idee und allgemeine Entwicklung der «Family by Choice» zeigen können. Auf eine spezifische Darstellung (die ja immer viel interessanter ist) der mannigfaltigen, individuellen Wirklichkeit mit ihren Problemen musste aus Platzgründen verzichtet werden.

Wenn ich im Titel gewagt habe, diese unsere Gemeinschaft, die

«Family by Choice», einen Weg der *Rehabilitierung des Menschlichen* zu nennen, so war ich mir der Anmassung dieser Aussage, aber auch ihrer Verpflichtung bewusst.

Es ist uns in unserem Haus bis jetzt gelungen, lebendige Freundschaften zu haben, die Ehen trotz all ihren Schwierigkeiten zu bewahren, die Kinder zu *sehen* und nicht nur zu betreuen, und miteinander zu leben, im Wissen um unsere Probleme und Möglichkeiten.

Wenn ich «bis jetzt» sage, so soll dies zeigen, dass wir uns unseres Gefährdetseins bewusst sind, da wir nicht wie eine Institution mit Regeln und einer zentralen, richtenden Autorität leben, sondern versuchen, dem, was jeweils da ist und sich ereignet, zu begegnen und gerecht zu werden.

Noch einmal die Mittel: Ausgangspunkt bildete die vorangegangene Einzeltherapie, die der Beginn des Offenseins war. Durch die nachfolgende Gruppentherapie wurde diese Offenheit aufrechterhalten. In unserer gegenwärtigen Lebensform hat sich die Offenheit immer wieder zu bewähren. Diese drei Mittel führen zu einer wachsenden Erkenntnis unserer menschlichen Möglichkeiten und Grenzen, und damit zu einer freieren Haltung dem Leben gegenüber.

Die «Family by Choice» lebt ein eigenes Leben, wie andere Gemeinschaften es tun, in einer Welt, von der sich das Mitglied als isoliertes Einzelwesen entfremden würde. Sie ist nicht nur eine Wieder-Anpassung, «die Fortsetzung der Krankheit mit anderen Mitteln», sie ist ein Kleinversuch einer neuen Familienordnung, in der der Kranke und der Gesündere, der Jüngere und der Ältere, der Begabte und der weniger Begabte sich begegnen und als Menschen mit eigenem Wert gesehen werden. Die Blutsfamilien finden sich in der Grossfamilie vereint als «Wahlfamilie».

Das Gedicht eines Kollegen drückt in seiner Form aus, was ich versucht habe darzustellen:

Unserem Hause
an seinem ersten Geburtstag
diese Wünsche:
Mauern, die atmen können,
Fenster, die ihre Arme offen halten,
Türen, die sich geben zur rechten Zeit,
Treppen, die Oben und Unten dienend verbinden,
ein Garten, der sich in Wohnzimmerwänden spiegelt,
ein Dach, das behütet, ohne zu verdecken –
und dass wir
mit Mauern und Fenstern,
Türen und Treppen,

Garten und Dach
umgehen können mit dem Danke der Liebenden,
das lasst uns wünschen.

Zum 19. September 1964

Zusammenfassung

Der Ausdruck «Family by Choice» meint eine Massnahme der Rehabilitation: es werden weder die Rückkehr noch die Eingliederung der Patienten in ein früheres Milieu, sondern die Schaffung einer neuen Umgebung bezweckt. Das Ziel ist nicht materieller Natur, sondern die Ermöglichung von Begegnung und Beziehung.

Das Experiment wurde vor 15 Jahren begonnen und umfasste anfangs 9, jetzt 65 Mitglieder verschiedener Berufe, Erziehung, Religion, Erkrankung und Altersstufen. Das Hauptmittel zur Offenhaltung von Beziehungen ist die regelmässige Gruppentherapie.

Summary

The expression 'Family by choice' refers to a rehabilitative measure: the aim is neither the return nor the reintroduction of the patients to their previous milieu, but rather the creation of a new environment. This is not a material goal, but the opportunity for encounter and contact.

The experiment was begun 15 years ago, initially with nine, and now with 65 members of different professions, upbringing, religions, diagnosis and age. The chief means of maintaining the relationships is regular group therapy.

Adresse der Autorin: Mrs. C. K.-Ginsberg, 1, Fabyc House, Cumberland Road, *Kew, Surrey* (England).

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Erfahrungen mit einem Hausparlament im psychiatrischen Krankenhaus

R. SCHINDLER und E. STEININGER

Siebte Abteilung des Psychiatrischen Krankenhauses der Stadt Wien
(Vorstand: Prim. Dr. R. SCHINDLER)

Seit das Stichwort von der «therapeutischen Gemeinschaft» durch die bahnbrechende Initiative von M. JONES und auch anderen für die moderne Psychiatrie als durchgesetzt gelten kann, hat sich die Problematik mit Recht auf technische Probleme verlagert. An ihrem Auftauchen lässt sich geradezu erkennen, wie ernst es der betreffenden Institution mit der Verwirklichung dieses Programmes ist. Fehlen sie ganz, so haben wir manchen Zweifel, ob überhaupt mehr als die Theorie in diesen Programmpunkt eingebracht worden ist. In jedem Fall lässt sich der angestrebte Prozess hinsichtlich seines Fortschreitens nicht auf den noch so aufgeklärten Aspekt eines einzelnen, etwa des Stationsarztes oder eines Psychotherapeuten, beziehen. Es ist klar, dass in ihm ein Entwicklungszustand für das Gesamt der zusammenarbeitenden Ärzteschaft, des pflegenden Personals in all seinen Spezialisationen und der behandelten Patientenschaft angesprochen ist und dass auch dieser innere Kreis nicht losgelöst von dem umgebenden administrativen Stab und der Aufgeklärtheit der Angehörigen, Dienstgeber und Nachbarn, also der Bevölkerung schlechthin betrachtet werden kann. Wir meinen daher, dass «therapeutische Gemeinschaft» in der Psychiatrie sich nicht einfach zu irgendeinem Zeitpunkt einführen, sondern nur anstreben lässt. Als wesentliche Impulsgeber der angestrebten Entwicklung sind dabei die Öffnung der Anstalt und die anwachsende Beteiligung der Patienten an der Gestaltung ihres Schicksals zu nennen, wie sie am eindrücklichsten bei Einführung eines Hausparlaments zum Ausdruck kommt. Solche Hausparlamente sind auch tatsächlich in neuerer Zeit in Stationen für psychosomatische Fälle und Neurosen, sowie bei Entziehungskuren und auch bei Psychopathien

häufig berichtet, vereinzelt auch für kleinere Rehabilitationsstationen psychiatrischer Kliniken, wie z. B. von HÄFNER.

Unser seit anderthalb Jahren laufender Versuch mit einem Hausparlament wurde in einem Pavillon mit 90 Betten durchgeführt, der ein Routinebestandteil unserer Abteilung ist und etwa ein Viertel unserer Kranken beherbergen muss. Die Abteilung als Ganze muss unausgelesen weibliche psychiatrische Patienten übernehmen und bestreitet mit ihrer Kapazität etwa ein Fünftel der einschlägigen Erkrankungen in Wien. Die Voraussetzungen lassen sich also auf die Durchschnittssituation psychiatrischer Anstalten, mit der Belastung des unausgewählten Krankenguts und der überdimensionierten Grössenordnung – die Abteilung gehört dem Organismus des psychiatrischen Krankenhauses mit insgesamt 2600 Betten an! – ohne weiteres übertragen.

Der ausgewählte Pavillon ist seit 1950 geöffnet. Die Patienten besuchen praktisch alle die verschiedenen Arbeitstherapien, soweit nicht ihr körperlicher Zustand, vor allem bei hohem Alter, dies verbietet. Einzelne besuchen eine Überleitungswerkstätte ausserhalb der Anstalt oder Kurse, die sie auf ihren künftigen Beruf vorbereiten. Die Patienten sind also sowohl hinsichtlich ihres Alters, ihrer Bildung, ihres sozialen Hintergrundes und ihrer Diagnose recht unterschiedlich, allerdings überwiegen diagnostisch die Schizophrenien. Schwere Oligophrenien sind im Krankengut nicht enthalten, diese werden in einem andern Pavillon der Abteilung zusammengefasst, da ihre Führung spezifische andre Probleme stellt. Auch bettlägerige Kranke werden hier nicht gepflegt. Diese beiden Krankheitsgruppen sind nur wegen der technisch andern Voraussetzung ihrer Führung abgesondert. Wir glauben, dass auf sie die Gesichtspunkte dynamischer Stationsführung ebenso anwendbar sind, wenngleich mit anderm Verbalisationsniveau und andrer Zielbildung. Für folgende Kranke sehen wir jedoch eine *Kontraindikation* aus der Situation ihres Krankseins:

1. Die akute psychotische Krise mit ihrem panikhaften Durchbruch zur Irrealität, ihrem Maximum an freier Angst und undurchsichtiger Uneindringlichkeit der Realität verlangt unseres Erachtens nach einfachen, übersehbaren und beharrenden Verhältnissen. Dies gilt auch für akut suizidgefährdete Depressive.

2. Ebenso werden voll desorientierte Verwirrtheiten bei organischer, meist arteriosklerotischer Demenz durch die Unabsehbarkeit des dynamischen Flusses überfordert. Beide Krankheitszustände verlangen gewisser-

massen ein therapeutisches Anhalten des Lebensflusses im geschlossenen System. Dies kommt auch im spontanen Symptombild zum Ausdruck: Zwänge, Verlangsamung bis zum stuporösen Beharren und Perseverationen verraten den Versuch einer Bewältigung des um sich greifenden Zerfalls durch eine möglichst enge, feststehende, fixierte Welt; katatone Kranke mit dem von ZUCKER beschriebenen Syndrom verlangen sogar ganz ausdrücklich nach dem Anhalten jeder Bewegung und jedem Ausdruck von Zeit. Wir glauben, dass auch die Psychiatrie der Zukunft für diese Kranke fixierte, geschlossene und einfach überschaubare Verhältnisse bereitstellen muss mit einer autoritär gehandhabten Ordnung.

Nun ist es der modernen Pharmakotherapie zwar wohl nicht gelungen, Psychosen zu heilen, wohl aber sie zu verwandeln: Die erwähnten akuten Krisen sind heute zu gut beherrschbaren Durchgangssyndromen geworden, das Schwergewicht der Therapie hat sich auf die Behandlung der instabilen Abwandlung, zu dem, was die klassische Psychiatrie despektierlich «Defekt» nennt, verschoben. Man kann von einem pharmakotherapeutischen Vorziehen dieser Abwandlung auf instabilem Niveau sprechen, womit aber bereits die Verlegung in die offene Station und die Teilnahme am Hausparlament, wie überhaupt am Fluss der Kontakte und Gruppen indiziert erscheint.

Schon 1957 konnten einer von uns und dann vor allem H. GASTAGER in einer grossen statistischen Studie zeigen, dass es für den Lebenserfolg nicht darauf ankommt, dass ein Patient einen schizophrenen «Defekt» hat, sondern *welcher Art* dieser Defekt ist. Dieses «welcher Art» entscheidet sich aber in der oft sehr lange dauernden instabilen Abwandlungsphase. Man kann zeigen, dass der soziale Erfolg einer solchen schizophrenen Persönlichkeitsabwandlung um so besser ist, je mehr der Patient in dieser instabilen Phase sozialgerechte Rollen einzunehmen vermag, um so schlechter, je weniger ihm das gelingt, wenn er also etwa isoliert bleibt oder sich an ein Sozialsystem anpasst, das gegenüber dem normalen Sozialleben verzerrt oder einseitig ist, wie etwa das in sich geschlossene Leben einer konservativen Anstalt. Die hohe Mauer, die früher psychiatrische Anstalten zu umgeben pflegte, kann heute nicht nur einfach fallengelassen werden, sondern muss durch ein umfangreiches System von Gruppenaktivität ersetzt werden, das es dem Patienten ermöglicht, in einer Stufenleiter von Annäherungen in sozialgerechte Rollenerfordernisse hineinzuwachsen. Der Rollenwechsel im Hausparlament widerspiegelt diesen Reifungsprozess oft sehr anschaulich:

Die langjährige paranoide Patientin K., 61 Jahre alt, ist erst seit kurzem in den Pavillon verlegt worden und eröffnet das Hausparlament vom 18. 2. 67 mit einem Entlassungswunsch. Einige Patientinnen finden das nicht hergehörig, weil es nicht die Allgemeinheit angeht, zahlreiche andere belächeln die Idee als solche, weil sie K. als noch recht gestört empfinden. Tatsächlich hat K. keinerlei Einsicht dafür, dass ihre Wohnung schon vor Jahren aufgelassen wurde, glaubt an irreale Vermögenswerte, entzieht sich jeglichem Kontakt auf der Station, übrigens auch immer wieder der ihr vorgeschriebenen neuroplegischen Medikation und lenkt sich von ihren Stimmen durch fleissiges Arbeiten in der Nähstube ab. Diese Haltung hat ihr eine gewisse Anerkennung bei den Schwestern des früheren Pavillons gebracht. Ihre Verlegung wurde von diesen auch nicht befürwortet und skeptisch beurteilt. Hier hat sie bisher gar keinen Rückhalt gefunden und nimmt eine Omega-Position ein, respektive hält sich aus jedem Gruppenkontakt heraus. Der ärztliche Teilnehmer der Sitzung stellt sich hinter die Patientin, indem er erklärt, dass der Entlassungswunsch ein durchaus allgemeines Anliegen sei, auch seitens der Ärzte und Schwestern, und dass das vorgeschlagene Thema wohl als Frage zu verstehen sei, wie man als Patient mithelfen könne und woran man erkennen könne, dass man bereits hinreichend gesundet sei, um den Schutz der Station nicht mehr zu brauchen. Die Gruppe nimmt diese Frage auf und bringt dazu zahlreiche Einfälle, wobei die Patientin K. sich mitbeteiligt und erstmals Anschluss nimmt. Unter den Beiträgen findet sich: Mitsorgendes Einhalten der Medikation, Verschwinden der Stimmen, und auch Sich-Loslösen-Können vom engen eigenen Interesse, Sich in die Sorge des andern einfühlen können und sich an ihr beteiligen. Jemand sagt ganz lapidar, man könne zwar seine eigene Gesundheit nicht merken, aber man könne merken, wie gut oder schlecht man sich in die Gemeinschaft hier einordnen könne; erst wenn man hier gut zurecht komme und sich wohlzufühlen beginne, könne man hoffen, dass es auch draussen gelingen würde. Über diesen Gedanken bemerken einige, dass man eigentlich sich an den Sorgen von Patientin K. bisher nicht beteiligt hat.

Tatsächlich findet Patientin K. ab dieser Sitzung Anschluss am Pavillon. Sie ist in den folgenden Sitzungen zurückhaltender, erweist sich aber in einer guten Gamma-Position. Sie findet auf einmal Verständnis für ihre Medikation und beteiligt sich an Untergruppen.

Die Hausgruppe vom 8. 4. 67 beschäftigt sich mit Problemen, die durch Inkontinenz und Orientierungsschwierigkeiten bei einer neu herverlegten Alterspatientin Z. entstanden sind. Man verlangt ihre Rückverlegung und findet darin auch die Unterstützung der Stationsschwester. Die 80jährige Patientin Z. versteht die Anschuldigungen nicht im einzelnen, fühlt sich aber von allen Seiten angegriffen. Obwohl sich der ärztliche Teilnehmer der Sitzung nicht eingeschaltet hatte, wendet sie sich gegen ihn und erklärt, er sei ihr auch verdächtig, er habe gewiss mehr Sympathien für die ihm besser bekannte Gemeinschaft der andern. Der Arzt bestätigt sofort, dass die Patientin damit recht habe, dass er die andern bereits länger und daher auch besser kenne, ja, dass die Gruppe überhaupt von ihr noch kaum etwas wisse. Er gibt ihr Gelegenheit, von sich zu erzählen und sie macht reichlich davon Gebrauch. Die bessere Leistung des Altgedächtnisses kommt ihr dabei zugute, sie wirkt jetzt geordneter, beruhigt sich auch und vermag einige Sympathien in der Gruppe zu gewinnen, die nun beschliesst, noch Geduld mit ihr zu haben und zu versuchen, ihr bei der

Einordnung mehr behilflich zu sein. Den Umschlag leitet unsre paranoide Patientin K. ein, die als erste darauf hinweist, dass die Gruppe sich auch bisher nicht um Patientin Z. bemüht habe und dass mit einer früheren, ebenso verwirrten Alterspatientin die Eingewöhnung und sogar Entlassung gelungen sei.

Im Mai beschäftigen wir uns mit dem Problem einer andern Alterspatientin von 85 Jahren mit einer Colostomie, die sich zwar recht gut wieder erholt hat, dennoch nicht mehr in der Lage scheint, allein mit einer Haushaltführung zurechtzukommen, jedoch keinesfalls ins Altersheim will. Wenn jemand ihr helfen würde, so ginge es. Patientin K. erklärt sich bereit, zu ihr zu ziehen; sie hat inzwischen realisiert, dass sie keine eigene Wohnung mehr hat. Auch die andere ist mit ihrer Hilfe einverstanden, und die Symbiose der beiden Patientinnen wurde unter Kontrolle des psychohygienischen Dienstes des Gesundheitsamtes auch tatsächlich verwirklicht.

Die hier dargestellten Parlamentssitzungen verfügen schon über die Tradition eines Jahres. Inzwischen hat das Hausparlament eine Entwicklung durchgemacht. Die Patienten haben gelernt, dass sie fragen und wünschen dürfen, dass es viel Gemeinsames gibt und dass man sich an sehr vielem beteiligen kann. Sie haben gelernt, Komitees zu bilden, die Spezialanliegen vorbereiten und vorlegen. Sie haben auch einiges erreicht: Sie haben Sportgruppen geschaffen, sie haben in formulierten Ansuchen an die Direktion und Verwaltung eine Einteilung für den Betrieb des Sportplatzes, eine Programmvorschau der alle 2 Wochen stattfindenden Filmnachmittage, Salz- und Pfefferstreudosen für den Tisch, die Auflage einer Tageszeitung und dergleichen erreicht, wobei das verständnisvolle Eingehen der leitenden Herren dankend erwähnt werden muss. Während etwa 2 Monaten war das Hausparlament damit beschäftigt, dem Pavillon eine eigene Hausordnung zu geben, die jetzt in zwei Exemplaren aushängt (siehe Anhang Seite 136). Immer wieder wurden Ergänzungen zugefügt, die z. T. auch auf Anregungen der Schwestern und Ärzte zurückgingen, wobei diese diskutiert und formuliert wurden, soweit man sie annahm. Als man endlich zufrieden war, wurde ein Exemplar auch der Direktion zur Stellungnahme eingeschickt, doch war keinerlei Veranlassung, daran etwas zu kritisieren.

Auch Ärzte und Schwestern haben gelernt. Die organisatorische Technik konnten wir beibehalten, sie hat sich bewährt. Um eine unüberschaubare Grossgruppe von mehr als 90 Menschen zu vermeiden, haben wir zwei parallel arbeitende Gruppen gebildet, die jeweils unter der ärztlichen Beteiligung des einen von uns tagten.

Dabei wechselten wir regelmässig, so dass sich die interessante Möglichkeit ergab, dass jede der beiden Parlamentsgruppen alternierend als ärztlichen Teilnehmer einmal einen Mann, das nächste Mal eine Frau

hatte. Infolge der übereinstimmend psychoanalytischen Ausrichtung ergab dieses System für uns nie Schwierigkeiten oder Nachteile, stimulierte jedoch natürlich verschiedene Schichten in der Patientenschaft, die ja durchwegs aus Frauen bestand und exponierte damit für die Diskussion vermutlich ein breiteres thematisches Feld, als es einem Einzelnen gelungen wäre. Wir verständigten uns untereinander durch Abfassung eines sachlichen Protokolls, das wir aus dem Gedächtnis nach jeder Sitzung anfertigen und in Durchschlägen jeweils dem andern Arzt und der Stationsschwester zur Verfügung stellen. Diese Protokolle, die somit gewissermassen für den Stab der Abteilung öffentlich aufliegen und natürlich auch von den Patienten eingesehen werden können, sind eine vielseitige und wichtige Informationsgrundlage. Sie gewährleisten einen gewissen Fortlauf des Gesprächs, das unter Umständen durch den Durchlauf der Station leicht allzu zerflattern könnte. Sie geben aber vor allem die Möglichkeit wertneutraler Schilderung von Vorgängen, die in der affektiven Dynamik des Geschehens nur dem Geübten sichtbar werden.

Die Teilnahme der Schwesternschaft durch den jeweils diensthabenden Vertreter scheint uns besonders wichtig. Ergeben sich doch in ihrer Ebene durch die Umwandlung autoritärer Ordnungen in ein dynamisches Partnerschaftssystem die grössten Probleme, die nur gemeistert werden können, wenn sie gesehen werden. Das Ernstnehmen des Patienten in seinen Anliegen gefährdet die bisherige scheinbare Sicherheit überlegener Autorität, aber unsicher lässt sich eine Station nicht führen. Erst die Erfahrung, dass die Patienten in ihrer Mehrzahl gerne anerkennen, beruhigt die anfänglich abwartende Skepsis. Es zeigt sich, dass das Hausparlament auch ein Forum ist, durch das Lob und Anerkennung zur Geltung gelangen und sichtbar werden. Und es zeigt sich, dass manche schwierige Veränderung durch die Mitarbeit der Patienten, die in der Diskussion des Parlaments den Sinn verstehen lernen, leichter zu meistern ist, als vorher durch autoritäre Anordnungen. Wir sahen das z. B. deutlich bei der notwendig gewordenen Umwandlung des bisherigen Raucherzimmers in ein Besuchszimmer.

Es ist uns nicht gelungen, einen bürokratischen Automatismus mit wechselnden Vorsitzenden und Stellvertretern nach angelsächsischen Vorbildern einzuführen. Vielleicht ist die Ausrichtung zum Arzt hin dafür noch immer zu stark, macht sich die Hemmung der Schizophrenen zu sehr geltend und liegt auch zuviel formale Ordnung nicht im Wesen unseres Landes. Uns erscheint wichtiger, dass ein freies, spontanes Gespräch entsteht, das die Patienten aus ihrer Unbeteiligtheit aufreisst und zur

Selbstgestaltung ihres Schicksals ermutigt. Als nach einjährigem Bestehen des Parlaments aus der Schwesternschaft die Idee einer Abstimmung über das Interesse an dieser Einrichtung auftauchte, ergaben sich 63 % Pro- und 37 % Kontrastimmen unter den Patienten, aber keine Stimmenthaltungen. Wir glauben, dass dieses wöchentliche Regulans unserer Atmosphäre und unseres Lebens uns inzwischen unentbehrlich geworden ist.

Zusammenfassend lässt sich sagen, dass die Einrichtung eines wöchentlich für 90 Minuten tagenden Hausparlamentes in einem psychiatrischen Krankenhaus sich nach den Erfahrungen von jetzt eineinhalb Jahren bei uns bewährt hat. Es sollte in einem Pavillon eingerichtet werden, von dem akut floride psychotische Krisen, suizidgefährdete Depressive und organische Verwirrtheitszustände ferngehalten werden, da für diese Krankheitszustände der dynamische Fluss therapeutischer Partnerschaft sich überlastend auswirkt. Ebenso sind Oligophrene und bettlägerige Kranke davon auszusondern, weil ihre Verbalisation, resp. Kommunikationsfähigkeit einen andern, eigenen technischen Stil verlangt. Bei einem durchschnittlich gemischten Patientengut lässt sich somit mindestens ein Viertel der Patientenschaft am Parlament beteiligen.

Übergrosse Parlamentsgruppen müssen in parallel tagende Gruppen von maximal 30–45 Patienten unterteilt werden, wobei die Verbindung durch Protokolle und Austausch wichtiger Teilnehmer, in unserm Fall der Ärzte, gewährleistet werden kann.

Die teilnehmenden Ärzte und Schwestern müssen sich gleichberechtigt fühlen und sinngemäss auf Grund ihrer speziellen Funktion und Ausbildung ihre Rolle übernehmen. Über jede Sitzung soll ein wertneutrales Protokoll geführt werden. Dieses gewährleistet die Kontinuität des Gesprächs der ja im Sinne des Durchgangs fluktuierenden Gruppe, lässt aber auch Aspekte deutlicher werden, die sonst in der Affektivität des Geschehens untergehen. Die Protokolle sollen allen Beteiligten zugänglich sein und damit eine wichtige Möglichkeit bieten, um die ja subjektiven, aber doch ernstzunehmenden und echten Anliegen aus dem Widerstreit der Affekte hervorzuheben und sichtbar zu machen.

Das Hausparlament erweist sich als ein Ort für Anregungen und gesunde Kritik, denen immer eine aufbauende Richtung gegeben werden muss. So vertieft es das gegenseitige Verständnis zwischen Patienten-, Schwestern- und Ärzteschaft und erleichtert auch die Durchführung notwendiger Massnahmen. Aber es ist auch ein Ort, der Anerkennung und Lob zur Geltung kommen lässt, und verhilft mancher stillen Bemühung zur verdienten Sichtbarkeit.

Der Vorteil, den uns die moderne Pharmakotherapie gebracht hat, könnte unseres Erachtens nicht ausgewertet werden, wenn wir dem solcherart zur Persönlichkeitsabwandlung hingeführten Patienten nicht die Gelegenheit zum Einnehmen sozialgerechter Rollen geben. Die Mauer der einstigen Anstalten soll nicht nur niedergerissen, sondern in ein Übergangsfeld von Gruppenkontakten verwandelt werden. Das Hausparlament nimmt darin einen integrierenden Bestandteil ein, in dem sich der Reifegrad aller konfluierenden Einflussfelder spiegelt.

Zusammenfassung

Eineinhalb Jahre Erfahrung mit einem Hausparlament im Psychiatrischen Krankenhaus der Stadt Wien haben uns diese Einrichtung als integrierenden Faktor der verschiedenen psychotherapeutischen Methoden und des gesamten Rehabilitationsprogramms erkennen lassen. Besonders für schizophrene Kranke ist das übende Einnehmen sozialgerechter Rollen von entscheidender Bedeutung für die Ausformung einer lebensgerechten Persönlichkeitsabwandlung (Defektbildung) und damit ihres sozialen Schicksals. Kontraindiziert erscheinen akute psychotische Krisen und voll desorientierte Verwirrtheiten bei organischer Demenz, da beide der vorübergehenden Ruhigstellung im geschlossenen System bedürfen.

Summary

Eighteen months' experience of a 'house parliament' in the Psychiatric Hospital of the City of Vienna has shown us that this institution can be an integrating factor for the various forms of psychotherapy and for the whole rehabilitation programme. Practice in adopting socially appropriate roles is of decisive importance, especially for schizophrenic patients, in helping them to attain an adequate modification of their personality, and thus in determining their future in society. It appears contra-indicated to allow patients to participate during an acute psychotic episode or a state of completely disoriented confusion arising from organic dementia, since both of these require temporary sedation in a closed ward.

Anhang

Beispiel des Ergebnisses einer Parlamentsaktivität: Die Verfassung einer Hausordnung

Liebe Patientin!
Du bist hier auf Pav. 25, auf einem sogenannten Heimkehrer-Pavillon, wo eine Arbeitstherapie für die Patienten eingeführt ist. Aus diesem Grunde ist es überall blitz-blank, eine Sauberkeit, die Dich gewiss erfreuen wird. Darum wirst Du auch gebeten, Dich in unsere Hausordnung mit gutem Willen einzufügen.

I.

Du wirst ersucht, den *Tagraum nur mit Hausschuhen* zu betreten. Vergiss dies bitte niemals, denn unser guter, lieber Hausgeist, der sehr streng sein kann, müsste Dich sonst zurechtweisen. Eine Zurechtweisung hat jedoch niemand gerne und so bin ich sicher, dass Du es lieber freiwillig *nicht* vergisst!!!

Ausserdem wird allgemein Wert darauf gelegt, *zu allen Mahlzeiten pünktlich im Speiseraum zu erscheinen*, um eine Hetzerei beim Abservieren zu ersparen. Sollte es einmal vorkommen, dass Du so spät mit Deinem Essen fertig wirst, dass bereits abserviert ist, dann bitte trage Dein Geschirr selber in die Küche.

Was die Tischordnung anbelangt, so gilt es, *alle Obstabfälle* (Bananenschalen, Apfelputz, Kerne u. dgl.) *selbst in den Papierkorb zu werfen*. Dieser ist zwar ausserhalb des Speiseraumes und noch dazu sehr versteckt, doch er lässt sich in der linken Ecke neben dem Stiegenaufgang trotzdem leicht finden und freut sich gewiss jedes Mal, wenn er aufgesucht wird; da doch niemand gerne alleine in einer Ecke steht; nicht einmal ein Abfallkorb! Gewaschenes Obst bitte so in den Speiseraum tragen, dass keine Wassertröpfchen auf den spiegelglatten Fussboden fallen, denn das bekäme seinem schönen Glanz nicht gut! Daher glaube ich, ist es selbstverständlich, dass man ihn durch besondere Achtsamkeit schont! Möchte ja auch seine liebevolle Pflegerin für ihre Mühe ein wenig Dank und Anerkennung finden.

Speisereste auf dem Essteller sind nach Einnahme der Mahlzeiten jedes Mal in *das Abstellgeschirr* zu leeren, welches still bittend auf der Kredenz zur Verfügung steht.

Wenn Du Deine Mahlzeit mit hoffentlich gutem Appetit und in Ruhe eingenommen hast, wirf bitte noch einen Blick auf Deinen Tischplatz und auf den Fussboden, um eventuelle Speisereste oder Tropfen mit eigener Ordnungsliebe zu beseitigen.

II.

Ausser unserer Tischordnung gilt es für die *ärztliche Betreuung* folgendes zu beachten:

Täglich zur Mittagszeit findet die ärztliche Visite statt, bei welcher Gelegenheit man alle Fragen stellen kann, die einem eventuell beschweren. Es wird daher auch aus diesem Grunde um Pünktlichkeit am Tischplatz ersucht!

Überdies findet täglich ab 8.30 h die *ärztliche Sprechstunde* statt für Anliegen,

die man gerne allein mit dem Arzt besprechen möchte. Diese Besprechung ist tags zuvor bei der Schwester Oberin anzumelden.

Der Herr *Primarius* hat seine *Sprechstunde* für Patientinnen jeden Dienstagvormittag, für Angehörige jeden Dienstagnachmittag von 13–15 h. In beiden Fällen ist vorherige Anmeldung bei der Schwester Oberin notwendig, damit die nötigen Unterlagen vorbereitet sind.

Was die *Medikamentation* betrifft, vergiss bitte nicht, dass Du Dich in einem Krankenhaus befindest, wo es diese ärztliche Verordnung in Deinem eigenen Gesundheitsinteresse *strikte einzuhalten gilt!* Es mag vorkommen, dass Dir manches Medikament nicht gut schmeckt, doch nimm es trotzdem! Medikamenten-Verweigerung oder Stillschweigen bei eventueller Unverträglichkeit würde Deinen Aufenthalt hier nur hinauszögern, was Du ganz bestimmt *nicht* willst! Du wirst daher bei jedweder Medikamenten-Beanstandung (sei es, dass Du glaubst, ein schwächeres oder stärkeres Medikament zu benötigen, oder eine andere Dosierung wünschst) aufgefordert, Dich vertrauensvoll an den Arzt zu wenden. Denn der Arzt, der Dir ja helfen will, ist verständnisvoll genug, um mit Dir zusammen eine passende Dosierung zu bestimmen. Du kannst und *sollst daher dem Arzt immer Vertrauen* entgegenbringen, auch dann, wenn Du keinen Grund für Deinen Aufenthalt einerseits oder zur Medikamentation andererseits selber erkennen kannst. Der Arzt handelt auf alle Fälle immer in Deinem Interesse und so kannst Du sicher sein, dass auch Deine Anhaltung hier *nicht willkürlich* bestimmt wird.

Ausser unserer Arbeitstherapie stehen jeder Patientin auch noch im Falle des Interesses «Musik- und Maltherapie» zur Verfügung. Nähere Besprechung und Auskünfte darüber sind jederzeit in der ärztlichen Sprechstunde erhältlich.

III.

Du siehst also, liebe Patientin, dass unser Pavillon Dir in jeder Hinsicht genügend Freiheit einräumt, die eine rasche und zufriedenstellende Genesung gewährleistet. So wurde u. a. auch für Deine *Unterhaltung* gesorgt: durch Radio, Fernsehen, Kino, Theater und Sport.

Fernsehen kannst Du jeden Abend im grossen Tagraum, wozu Dich auch das Fernsehprogramm an der Wand freundlich einlädt. Bezüglich des Radiohörens wird insoferne um Rücksichtnahme gebeten, indem man sich hiebei der Mehrheit anschliesst.

Das Kino ist alle 14 Tage im Theatersaal (ausserhalb unseres Pavillons) jeden Mittwoch um 15.30 h. Theaterspiele werden jeweils verlautbart. Beide Unterhaltungen sind kostenlos! Wir gehen zu diesen Vorstellungen immer geschlossen.

Und damit Deine Glieder während Deines Aufenthaltes hier in der Anstaltszeit nicht erlahmen, bist Du gerne zum Korb-Ball oder Tischtennis eingeladen.

Korb-Ball ist jeden Montag, Mittwoch und Freitag nach der Arbeit auf dem allgemeinen Sportplatz im Freien. Für *Tischtennis* steht uns einer der Kellerräume zur Verfügung; jedes Weggehen ist der diensthabenden Schwester zu melden.

Ausser diesen Vergnügungen aber hast Du auch Gelegenheit, jeden Sonntag den *katholischen Gottesdienst* um 9 h vormittag oder den Nachmittags-Segen um 3 h in geschlossener Gruppe in der Anstaltskirche zu besuchen.

Die Zeiten des evangelischen Gottesdienstes sind auf der schwarzen Tafel im Gang ersichtlich.

Während der freien *Spaziergänge* – die auch immer der diensthabenden Schwester zu melden sind – wird vom Herrn Primarius zu Deinem eigenen Schutz und aus Gemeinschaftsinteresse gewünscht, Du mögest Dich *immer irgendeiner kleinen Spaziergänger-Gruppe anschliessen.* Vergiss jedoch nicht, über all Deinen Gesprächen, auch den wunderschönen, stillen und duftspendenden Bäumen innerhalb der grossen Parkanlage, sowie den Blumen und dem Sonnenschein Deine Aufmerksamkeit zu schenken. Auch die Vögel und Eichkätzchen, die vielfach unsere Wege kreuzen, würden sich freuen, wenn Du ab und zu einen Leckerbissen für sie übrig hättest. Sie danken's uns allzeit durch ihre possierlichen Tiermanieren, die leicht unser Herz erfreuen lassen.

IV.

Ausgänge nach Hause werden vom Arzt nur bis zu 2 Nächten (an Feiertagen bis zu höchstens 3 Nächten) bewilligt, da während dieser Zeit die Verpflegungskosten unberücksichtigt weiterlaufen, was bei Privatpatientinnen eine finanzielle Einbusse darstellen würde. Mit dem Ausgangsschein sind sodann die Privatkleider, falls diese nicht im eigenen Pavillon aufbewahrt sind, vom Hauptkleidermagazin abzuholen.

Für anstaltseigene Kleidung (auch Handtücher) hat sich jede Patientin bei Bedarf immer an eine diensthabende Schwester zu wenden. Es ist regelmässig jeden Montag Handtuch- und jeden Donnerstag Kleiderwechsel.

Wenn z. B. eine Patientin fühlt, dass sie nicht mehr anstaltsbedürftig ist, kann sie jederzeit beim Arzt entweder um eine längere Beurlaubung nach Hause bis zu 6 Monaten maximal oder um direkte Entlassung ersuchen.

Die Beurlaubung hat gegenüber der endgültigen Entlassung den Vorteil, dass die Patientin bei eventuellem Krankheitsrückfall oder sonstigen privaten Schwierigkeiten, die sie noch nicht selbständig bemeistern kann, jederzeit ohne Ansuchen wieder in die Anstalt zurückkehren kann. Bei Ablauf der vom Arzt bewilligten Urlaubszeit, die unbedingt einzuhalten ist, muss die Patientin anschliessend ihre Entlassung beim Anstaltsarzt entweder draussen (in der Gruppentherapie) oder in der hierärztlichen Sprechstunde beantragen. Bei gutem Gesundheitszustand kann jedoch die Patientin über beide Ärztestellen entweder um Urlaubsverlängerung oder um direkte Entlassung ersuchen.

V.

Liebe Patientin, unser Pavillon, der in jeder Hinsicht musterhaft geführt wird, möchte deshalb gerne auch den Besuchern gegenüber sein gutes Ansehen wahren, und so wirst Du eindringlich gebeten, jedes Zigarettenbetteln zu unterlassen. Dieser Wunsch soll auch intern unter Raucher-Patientinnen beachtet werden. Ausserdem gilt es, das *strikte Rauchverbot in den Schlafsälen* und Closetts *unbedingt* einzuhalten. Bei Nichteinhaltung dieser Vorschrift müsste der betreffenden Patientin der Zigarettenvorrat konfisziert werden, und ich denke, so weit wird es kaum jemand kommen lassen. Ist doch Selbstbeherrschung gerade dort, wo es am schwersten fällt, immer am wirksamsten zu seinem eigenen Guten!

Was die *Raucherdisziplin im Raucherzimmer* anbelangt, wirst Du ersucht, während des Servierens und Abservierens *nicht zu rauchen*. Ich denke, es ist selbstverständlich, dass man vor allem auch die Medikamentenverteilung abwartet. Um diesen Aufruf nicht zu überhören, werden alle Patientinnen gebeten, den Speiseraum (auch Raucherzimmer) nicht eher zu verlassen, bis dieser Anordnung Folge geleistet ist.

VI.

Für allgemeine Beschwerden, Anliegen oder Vorschläge für Verbesserungen findet jeden Samstag ein sogenanntes Hausparlament statt. Herr Primarius und Frau Oberarzt wechseln sich hierin in den beiden Tagräumen ab, wobei Frau Oberarzt um 8 h und Herr Primarius um 8.30 h beginnt.

Unter Darlegung unserer Ordnungsgrundsätze hoffe ich, dass diese Dich in keiner Weise belasten, sondern im Gegenteil eher mit Freude anregen, Dich in unsere Gemeinschaft einzugewöhnen. Und so bin ich auch sicher, dass Dir die von uns vorausgesetzte Hilfsbereitschaft im Bedarfsfalle nicht schwer fallen wird. Denn immer und überall in unserem alltäglichen Leben gilt das Sprichwort:

«Wer andern hilft, der hilft sich selbst.»

Das Hausparlament
des Pav. 25
im Oktober 1966

Adresse der Autoren: Dr. R. SCHINDLER und Dr. E. STEINIGER, Psychiatrisches Krankenhaus der Stadt Wien, Baumgartnerhöhe 1, *A–1140 Wien* (Österreich).

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Rehabilitation through Psychotherapy in a Residential Setting

Ch. P. Neumann

The Silver Hill Foundation, New Canaan, Conn.

Emotional illness has been recognized for centuries, but public acceptance of emotional illness, accompanied by the positive concept that emotional illness could be treated with gratifying results, is a development of the last twenty years. Unquestionably, this is a result of World War II. More persons, both in military and civilian roles, were actively involved in this conflict than ever before in the history of the world. Consequently, more persons than ever before in the history of humanity were subjected to new, unknown and excessive stresses and strains, which in turn precipitated more emotional illness than in any previous period of history. Coincidentally, psychiatry had advanced to a point where it was a recognized and respected area of medical practice, and psychiatrists were a regular and usual part of every military medical organization. Emotional disorders were, for the first time in a combat situation, promptly and correctly diagnosed and immediately treated with successful results culminating, most often, with complete rehabilitation and return of the involved individuals to a happy and productive life. Because of this, the public gained its first understanding of psychiatry and what this new medical specialty could do for individuals unhappily involved with emotional illness.

The rapidly increasing interest in the rehabilitation of the emotionally ill, particularly in the United States, spread to every community, and there it seemed to come to rest and into focus. With considerable logic it was argued that the local or community environment allowed not only earlier detection of emotional illness, but psychotherapy which could be carried on with the least disruption of an individual's life. The concepts of psychotherapy expanded explosively; and a convocation such as this is

evidence of the need for continuing reappraisal of psychotherapies and rehabilitation methods, as well as providing an opportunity to acquire new information and note changing trends in this area.

To the original psychoanalysis has been added the eclectic therapies, group therapy, somatotherapies and the most recent advances in psychopharmacology. The results of these efforts in the rehabilitation of the emotionally ill have more than proven the value of such programs, and without any hesitation, I agree wholeheartedly that they should not only be continued, but undergo further development and refinement.

In the reflection of such obvious advancement and success, one is most reluctant to sound anything which might be interpreted as a dissident or discordant note. This is indeed not my intention. But I cannot refrain from a feeling that the enthusiasm for psychotherapy and emotional rehabilitation at a community level has caused many of us to forget, at least momentarily, that there may be other rehabilitative methods which, in certain instances and in selected cases, might be more valuable. And it is my hope to bring to your attention today a most valuable method of rehabilitation which, though sometimes forgotten, has not yet gone into eclipse, and I am certain never will.

Initial overenthusiasm for the new invention, a new process, or a new method is not at all unusual, and the combination of time and experience invariably brings anything new into perspective. For example, in America when the automobile was first invented, it was predicted that the horse would become totally obsolete. But even today any American cowboy will readily tell you that he can go many, many places on his trusty cowpony that would be totally inaccessible to his General Motors truck.

Hospitalization versus residential treatment

I am concerned here with the role of psychotherapy in a residential setting and of its continuing importance and value in the rehabilitation of the emotionally ill today. I trust that I will not stand accused of dwelling on semantics, but nevertheless I am purposely being very careful to use the term *residential setting* and not the phrase *hospital setting*. To me this terminology is important because I associate much of the lack of present-day understanding of the value of this methodology to the belief that these terms are synonymous. In realistic terms they are not.

Unfortunately, the generally accepted 'raison d'être' for *hospitalization* of the emotionally ill has its roots deeply implanted in the past – many

centuries of the past. Even today in the United States the criteria for hospitalization is reflected in the jurists' approach in many states to commitment or involuntary hospitalization. It is all too simple, and reflects anything but a rehabilitative approach. All too often the only reason for hospitalizing the emotionally ill is the concern of whether the particular person is a danger to himself or to other people.

This attitude is, in my personal opinion, archaic, and actually not reflected today by the programs currently implemented by hospitals for the emotionally ill. They too have taken advantage of the forward movement in psychotherapy. All hospitals in this era, whether they be public or private, are successfully returning more patients to the community than ever before. Thus, I am in no way critical of hospital treatment per se; indeed, to the contrary, you will learn that I am an advocate. But, I am averse to such a narrowed and antiquated reasoning for *hospitalization.* And this perhaps explains my concern for terminology.

In an effort to divorce the past from the present and the future, I therefore prefer to relegate the word *hospital* to the past centuries, and relate the term *residential* to present-day thinking.

Elective treatment

As a proponent of the philosophy of psychotherapy in a residential setting as it is applicable to modern psychiatric thinking, I note striking differences from the attitudes for hospitalization in the past. First and foremost, the 'raison d'être' for this type of therapy is not that it is the necessary or the only treatment, but rather that it is a treatment of choice. For certain persons this option may result in the most effective treatment in the shortest period of time. It is inherent in this philosophy that any patient who elects this procedure must have, of necessity, not only recognized that he has emotional problems which are impairing his total function, but be motivated also to analysis and intensive treatment of his emotional difficulties.

If the group, such as would be found in residence in a program of this type, is so well motivated, then the atmosphere of a truly *open hospital* can be established. This does not deny the fact that some persons, even though well motivated, will be too ill or too disturbed to be allowed complete freedom of action. These persons, however, can be cared for in an area of *intensive care* where constant observation and adequate security obviate the necessity of any *locked ward* concept. Further, because of the

broad spectrum of diagnostic categories which will enter into such a residential therapy program, an overall plan of progressive levels of psychiatric care is an important part of the planning. These varying levels of care should range from the intensive care unit, on the one hand, to totally open convalescent areas.

The capacity of such a residential psychotherapeutic unit is, for many reasons, of great importance. I believe the optimum number in residence to be not less than 60 and not more than 72 persons. Also, the population should be fully ambulatory, which means of course, that chronic illness quite obviously does not fit into or receive particular benefit from such a program. In addition, such a program is best carried on in a rural environment, as this permits more comfortable surroundings and a greater freedom of action for those in residence.

Treatment program

What is the therapy offered in such a program and what are its special benefits? Treatment may be described as fourfold.

1. The patient who comes into residence is able to remove himself from his family, his work, and the stresses of everyday living. Remaining in the community may not prevent successful psychotherapy there, but continuing to deal with these factors must certainly be at least diverting from the final goal, and would undoubtedly slow the course of recovery. Instead, he has elected to place himself in a structured and comfortable environment, comprising few enough other residents so that he remains an individual and is not regimented as just another number, which most certainly would occur if the facility were two to three times the size. Here, he can relax and devote his entire energy toward his emotional problems and their solution.

2. Psychotherapy should be intensive, and the patient should undergo psychotherapeutic sessions three to five times a week. Again, because of the size of such a unit, therapy can be eclectic, dynamically oriented and individualized. Surprising benefits can accrue to a patient through this approach in an amazingly short time.

3. The daily program, or schedule, in which each resident patient is involved shortly after admission, should begin with a scheduled hour of arising and end with a prescribed time for retirement. The daylight hours are planned with specific times for meals and with regular appointments

in the occupational and physical therapy programs, both morning and afternoon. The importance of this part cannot be overemphasized. Persons suffering with emotional difficulties invariably have allowed their physical well-being to deteriorate and the organization of their daily life to fall into total disarray. A most important part of any such individual's total rehabilitation through this program is the re-establishment of good physical health and a regular pattern of day-to-day living.

4. The final segment of the program is the experience of communal living in this environment. Most persons who elect this program have become aware that their ability to handle interpersonal relationships has been severely jeopardized. In an environment of this size (and again the size is important), these individuals are in constant association with others and in small enough numbers that with amazing rapidity they relearn successfully the handling of interpersonal relations. This is another most important part of the rehabilitative process.

It should be noted very clearly, however, that the patient while in residence is not placed in a totally isolated environment, separated from friend and foe alike. Invariably, the family is an important part of the psychotherapeutic plan. Employers, as well, often are seen by the attending psychiatrist or a social worker. Herein is perhaps one of the most important but least recognized benefits of the residential program. This might be described as the benefits derived from the separation of two or more individuals who have been so long involved in an antipathetic or symbiotic relationship that, if they remain in continued control with one another, total destruction of the relationship is inevitable. The two prime examples are the marriages that seem doomed to dissolution, and the person who is about to lose gainful employment. Separation of spouses allows not only a respite from the emotional irritants of one another, but also, during this respite, permits a reappraisal of the opposite party. Frequently, this in turn leads to a new perspective toward one another, and this becomes the keystone for a continuing and happy relationship for the remaining lifetime. The same mechanism is applicable in the interaction between an employee and employer that seems headed for an unhappy termination.

Costs

The question invariably raised in any discussion of psychotherapy in a residential setting is the seeming high cost of this program. This truly is

a misapprehension; it arises because the total cost is incurred in a very short period. Yet our experience has proven that those persons who achieved substantial benefit from this program did so in an average stay of 61 days. If one were to compare the cost of this program with the cost of an individual in office therapy once a week for two to three years at standard private fees, or even at the costs of publically supported clinics, the difference would be surprisingly negligible. But more importantly, in the United States an increasing number of medical insurance programs are including this type of care in their benefits, and many forward-looking corporate programs underwrite 100 % of such coverage. Industry is accepting more and more the wisdom of this policy, as it recognizes that emotional problems can be solved not only through this philosophy of psychotherapy, but other disciplines as well and that many valued employees can be successfully salvaged for additional years of happiness for themselves and equal years of service to the company. In simple terms, businessmen are learning that psychotherapy in any form is a very sound investment.

Summary

The author in this dissertation, and in concordance with his confreres in psychiatry, takes note of the great advances in psychiatry, and points with particular pride to the past twenty years. But, at the same time, he utters a word of caution that in this new and growing enthusiasm for psychiatry by the general public, particularly for a community centered program, other valuable methods of psychotherapy should not be overlooked.

This author is particularly interested in a wider recognition of psychotherapy in a residential setting on a voluntary or elective basis. The reasons for this author's enthusiasm for this type of psychotherapy have been fully delineated in the corpus of this paper.

Particular emphasis is placed on the term *residential therapy,* as opposed to *hospital therapy,* as the author feels the latter term has become synonymous with involuntary admission and is outmoded, while the former term epitomizes this modern philosophy for a most valuable method of psychotherapy.

Author's address: CH. P. NEUMANN, M. D., Medical Director, The Silver Hill Foundation, Valley Road, *New Canaan, Conn. 06840* (USA).

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The Use of Dynamic Groups in Psychiatric Staff Reorganization

H. MULLAN

Department of Psychiatry, Georgetown University School of Medicine and Area C Community Mental Health Center, Department of Public Health, Washington, D. C.

Introduction

In mental health facilities in the United States it is a common practice to change the organization, operations and goals of a department, or the institution as a whole, by bringing in a new departmental head. Today, because of the proven value of milieu therapy, the new departmental head views the staff as one group, interacting with the group of patients, altering their behavior in a constructive fashion. Thus the newcomer's point of view is both psychological and sociological.

The modifications, when they come about, occur with severe conflict and disturbance in both the staff and patient groups. The bringing about of a new order causes conflicts in each staff member: past rigid practices are clung to because of fear of change and because of personal investment. Under these circumstances the duties of the new department head are difficult. It is hard to interrupt the status quo: the innovator finds his wishes and his new treatment design ignored.

The purposes of this paper are threefold: 1. to describe the reorganization of a psychiatric staff in a department of a general hospital; 2. the use of dynamic groups in the reorganization, and 3. beneficial practices which tend to prevent pitfalls during the change over period.

Investigators who describe the therapeutic community suggest that the optimal approach to patients occurs when concerned mental health specialists hold certain attitudes in common and thereby obtain an integrated activity. When a new treatment design is suggested it is necessary then to modify the professionals' points of view, and methods of

intervention. These must, to a degree, become congruent with those of the new head of the department. A series of sociological and psychological transactions are essential to bring this about.

The innovator, from time to time, during this transitional period must detach himself from the heightened interaction which develops on his service. He must view from afar what he sees going on around him and then make decisions. He is judgmental, desiring change from older methods of operation. But the new department head is non-judgmental concerning the staff members' resistant behaviors, realizing that they are fearful of anything 'new'. As one key professional said, 'Since your arrival I have felt completely castrated'. The innovator's response must not be retaliatory. His actions are motivated for the good of the patients and not based upon bias or vindictiveness.

The nature of resistance to change

It seems paradoxical that commitment to change, an attitude which psychotherapists must have, is many times lacking in staff members in the institutional practice of psychiatry. When a person is brought in from the outside to direct a department, this fact in itself is felt to be a criticism of the past operation. New approaches and outlooks are resisted because they challenge each member's competency. To paraphrase, the questions which arise in challenged staff members are, 'How will he find me?', 'Will he reassign me?' 'Will he let me go?', 'What *new* duty will he make me perform?' All changes imply deficiencies in present operations. Staff can accept a new chief being chosen from among them, better than an outsider.

The innovator's task becomes much more difficult when interdisciplinary rivalries are high; when there is no respect among staff members for each one's differing function; when there is neither affective communication nor mutual understanding. Resistance is also high when the service is dominated by medical thought and practice. Thus, those psychiatric services which rely heavily upon electro-shock therapy and medication, and those dominated by research, are proportionately resistant to alteration. Those persons on the staff who have vested interests and who wish to keep their own islands of activity intact, fight tooth and nail to do so. They use other staff members to support their resistance. Their tendency is to comply to the new order but secretly they fight it. Other sections of the hospi-

tal and other professionals not in the department may become involved: the hospital director, and even the patients themselves will be brought into play against the innovator and his new methods.

Methods of overcoming resistance

The new philosophy is more readily accepted by those of lower professional status. Thus, agreement with new ideas comes first from attendants, and then progressively from nursing assistants, nurses, volunteers, social workers, psychologists, and finally physicians. Many times physicians find it difficult to meet with others for fear that their authority and knowledge will be questioned.

The new philosophy is gradually brought into being through series of meetings; staff, social, educational, consultation, supervisory, and so forth. In all of these meetings, the leaders must be in sympathy with the new philosophy as against the old. For example, a lecturer or a consultant must be dynamically oriented, aware of group processes, and function in an interactional manner rather than in a didactic one. The content of lectures must also focus upon the new methods and goals rather than the old ones. For example, in altering the service and making it more humane, lecturers must devote their time to discussing the relatedness of patients, their rehabilitation, their social contacts, their vocational activities, the patients' relationship in their families, and so forth.

The small experiencial group

The best method of changing staff attitudes so that they can present an altered, and consolidated approach to patients is to use the experiential staff group. These groups, meeting once a week, or once every two weeks, come together fairly easily, using as stabilizing factors, mutual concern about patients, work ties, and friendships. These groups should be conducted by trained group psychotherapists from outside the institution. At first didactic, the group becomes experiential as the subject shifts from patients to the staff members themselves. At first, the staff will be unwilling to question themselves and they will support the service's older structure and methods. At first, too, they will seek a usual classroom presentation, rather than to participate themselves. Difficult cases may be brought

up, evading a more personal interplay with feeling. Gradually, however, depending upon the facility of the leader and when trust has been established, these staff members of different disciplines agree and disagree, express their likes and dislikes, and generally become much more personal and communicative.

A unique experience is required to alter rigid staff attitudes, to clarify and modify members' roles, and to gain some congruence of ideas about the mentally ill and their treatment. The usual case presentation where patients are thoroughly and systematically discussed, although an excellent teaching device, is not helpful in this connection. It is the interacting staff members themselves, their emotions, anxieties and relationships to one another which must become the focus of the small group leader. However, unlike group psychotherapy, the discussion of past family, early traumatic and sexual experiences are avoided. The consultant who has come from outside, carefully focuses upon the present, overloking historical causes for the behavior. Transference reactions are curtailed by offering relatively few sessions, or infrequent ones. The consultant keeps all the material that comes up in these groups quite confidential and does not bring any of it to bear on the promotion or disposition of any staff member.

Gradually, the staff members find that they can no longer be complacent students, nodding in agreement with the expert. Then suddenly they begin to wonder why they are present and who their neighbor, another staff member, actually *is*, and what it is that they are all doing together. Gradually, through these face to face meetings, the group atmosphere changes, resulting in each person changing toward himself, the others and the patients. The staff members become much more open and concerned with one another. They see a blending between their treatment goals and those of the new head of the department.

In a sense, all meetings as far as possible, are of the cross-status variety requiring the presence of psychiatrists, social workers, psychologists, nurses, and so forth. In every instance, there is a coming together of attitudes and a reshaping of relationships and understandings. In each of these experiences, whether formal or informal, there is a demand that staff persons change themselves and change towards one another. Particularly in the experiential group, as there are no guide lines to support a member in his accustomed behavior, he soon develops by trial and error, similar to 'on the job training', a new way of being with others. As staff members go through the various meetings, they are constantly faced by processes which make them sensitive to conscious and unconscious determinants in

their behavior and that of others. Hopefully, the newly acquired ability to express feelings and concern for one another in an anxious self-questioning environment, is carried over to other persons including patients in groups. Naturally, a desired result which does occur from this experience, is a modification of each member's group functioning.

Staff groups gain in many other ways. There is a lessening of harmful rivalries, increased cooperation, and a deepening respect for peers, supervisors and administrators. And finally, staff members are fortified and supported by these meetings and present a new consistency in their behavior toward patients.

Avoidance of pitfalls

There is no certain way to avoid upsetting episodes in the department as one takes over. Times of friction are to be expected and used. Stormy staff meetings, periods of seeming disintegration, are followed by calmer meetings of reintegration. Workers get to know one another at these times, communicate freely and differently and are reassured when they realize that they are not friable.

Opportunities abound for key professionals to act out against the new department head. His leadership role requires partial delegation of his authority to others who, because of their older loyalties or hurt feelings, do not fellow through. Thus, a guest lecturer on arriving at the airport was overlooked by a staff member delegated to escort him to his hotel. Meetings are missed, records are unprepared, reports late, and so forth.

The departmental head must assure himself before he begins his new duties that the power invested in him is real. Once starting, he must test his new power and see if he is backed by management. When this is determined and when the staff members are aware of it, his task is somewhat easier. If management, i. e. the medical director, is not solidly behind the department chief, his position becomes intolerable.

The department head surveys the activities, roles, and associations of his key persons. He must search for and find, if present, the 'hidden' leader who dominates the service by the force of his personality and who secretly exploits the service for his own purpose. This person's investment will be great; his stay on the service long; and his friends many and vocal. This 'hidden' leader's continued value to the service is doubtful. He usually has withstood many changeovers. He withdraws from staff interaction unless he can dominate and tyrannize, he leads in subtle ways a rebellion

against the chief, divides the staff and spreads rumors. He reacts violently to any change in his duties. His three possible behaviors when divested of his position and singular prerogatives are to 'comply, fight, or resign'. His loyalty to the hospital, the service and the new chief is in doubt. In most instances, therefore, he must be reassigned to a new institution.

Summary

Change in psychiatric care, treatment and goals of an institution or a department can first be brought about by assigning a new department head and second, by a focus upon group meetings. The interactional meeting, conducted by an outside group therapist, is the most helpful in changing staff members' attitudes.

Change brings discomforts to many. The 'hidden leader', if present, must be discovered and relocated. His loyalty is to himself and not the institution.

Friction abounds in such a turnover. A clear understanding with management (the medical director) and having this support is essential in the gradual modification of the department.

Author's address: Dr. H. MULLAN, Area C Mental Health Center, 1905 E Street, S. E., *Washington, D. C. 20003* (USA).

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Aus welchen Motiven kommen Psychotherapiegruppen in der Psychiatrischen Anstalt zustande?

P. Petersen und A. Uchtenhagen

Psychiatrische Universitätsklinik Burghölzli Zürich
(Direktor: Prof. Dr. M. Bleuler)

Im Laufe der letzten Jahre wurden im Zürcher Burghölzli gegen dreissig verschiedene Therapiegruppen ins Leben gerufen. Wir folgten dabei keinem systematischen Programm, sondern den Bedürfnissen der klinischen Arbeit; die Gestaltung der Gruppen blieb den Therapeuten – fast durchwegs Ärzten unserer Klinik – weitgehend überlassen. Von den dabei gewonnenen Erfahrungen her möchten wir drei Fragen nachgehen: 1. Welche Motive veranlassten die Therapeuten zur Gruppengründung? 2. Warum verschob sich im Laufe der Zeit das Schwergewicht von den ausgesprochen analytisch deutenden Gruppen zu den Aussprache- und Aktivitätsgruppen? Und 3. welche Konsequenzen hat die Motivuntersuchung für die Ausbildung der Gruppentherapeuten?

Die Struktur des Burghölzli hat wesentlichen Einfluss auf unsere Gruppenerfahrungen gehabt. Als eine für die Schweiz typische Mehrzweckanstalt ist es nicht nur Universitätsklinik, sondern auch kantonale Heilanstalt mit chronischen und Alterspatienten. Herkunft und Milieu, Krankheit und Krankheitsverlauf und die Einstellung zur Hospitalisierung sind von Patient zu Patient recht verschieden, auch in den Augen der Patienten. Wechsel im Ärzteteam sind recht häufig. Auch Kollegen, die nicht Psychiater werden, verschaffen sich hier während höchstens ein bis zwei Jahren eine psychiatrische Schulung. Der einzelne Assistenzarzt ist nicht nur für durchschnittlich 2–3 Neuaufnahmen pro Woche verantwortlich, sondern auch für die Betreuung der rund 60–90 Patienten seiner Krankenstationen. Bei weitgehender therapeutischer Selbständigkeit der Ärzte ist die Direktion durch eine straffe Organisation auch über detaillierte Belange der Klinik informiert. Viele Kollegen stehen in psycho-analytisch-psychotherapeutischer Ausbildung und haben nicht selten Mühe,

individualtherapeutische Massstäbe mit der klinischen Arbeit in Einklang zu bringen, vor allem auf den grösseren Krankenstationen.

Das vorliegende Referat ist hervorgegangen aus einer Arbeitsgemeinschaft von Gruppentherapeuten der Klinik, deren grösster Teil sich zugleich zu einer Selbsterfahrungsgruppe zusammengefunden hat. Diese Arbeitsgemeinschaft befasst sich seit einem Jahr mit der kritischen Sichtung der bisherigen Gruppenerfahrungen, und zwar vorwiegend mit den für sie unbefriedigend verlaufenen Experimenten. Dabei wurde es erst im Laufe der Zeit klar, wie sehr die Motive zur Gruppengründung über das Schicksal einer Gruppe entscheiden können. Da wir unsere Motivuntersuchung in gezielten, selbstprüfenden gemeinsamen Diskussionen betrieben, tragen die Resultate eine eher spontane und persönliche Note; eine schriftliche Erhebung mit Fragebogen hätte – was sich nach dem Gang unserer Gespräche vermuten lässt – ein höheres Mass an distanziert-theoretischen Überlegungen ergeben. Was hat nun die Kollegen dazu veranlasst, sich der Gruppentherapie als zusätzlicher Aufgabe zuzuwenden?

An erster Stelle stand eine klinische Alltagserfahrung: ein entschiedenes Unbehagen der Kollegen bei der Betreuung ihrer Krankenstationen. Die unterschiedlichen Anliegen und Einstellungen unserer Patienten schaffen auf fast allen Stationen spontane Gruppierungen, die zum Teil auf Gemeinsamkeiten des Abwehrverhaltens beruhen und damit einen ausgesprochen therapiefeindlichen Charakter besitzen. Unerfüllbare Ansprüche der Patienten an die persönliche Aufmerksamkeit der Ärzte, wiewohl oft genug als krankhaft erkannt, lassen das unbehagliche Gefühl eines therapeutischen Ungenügens aufkommen. Das Unbehagen kann eine besondere Note dann erhalten, wenn der Arzt ausserdem eine analytische Ausbildung durchläuft. Weiterhin muss der Arzt als Administrator die individuellen Bedürfnisse der Patienten berücksichtigen – eine nie versiegende Quelle für Verbitterung, Eifersucht und Intrigen. Oft genug bleiben diese mannigfachen Spannungen eine lediglich erspürbare Atmosphäre. Ihre verborgene Dynamik im Schutze einer geleiteten Gruppe zur Entfaltung zu bringen und zu artikulieren, die Atmosphäre zu entladen und zugleich das eigene Unbehagen loszuwerden, erwies sich uns als häufigster Beweggrund zur Bildung von Therapiegruppen. Dazu kommt, dass der Anstaltsarzt sich oft genug in die Rolle eines Funktionärs und in eine Autoritätshaltung gedrängt sieht, in der er sich nicht wohlfühlt und die seine eigentlich therapeutischen Anliegen unbefriedigt lässt.

Einige Beispiele mögen illustrieren, wie aus dieser Konstellation heraus Gruppentherapien begonnen wurden, nicht nur und nicht in erster

Linie als eine Methode zur Behandlung von Patienten, sondern weil sie dem Arzt auch zu einer therapeutischen Haltung verhelfen, die er sucht, weil das Anstaltsleben auf den Krankenstationen sie von ihm fordert. Der Arzt einer Aufnahmestation etwa, täglich mit erstmals und zwangsweise hospitalisierten Patienten konfrontiert, empfand bei der üblichen Visite nicht nur einen Mangel an gegenseitiger Information. Als er begann, alle neu Eingetretenen zu gemeinsamen Aussprachen zusammenzurufen, stellten sich oft schlagartig Beziehungen zu Patienten her, die sonst unzugänglich und unvertraut blieben. Er gewann einen raschen Überblick über die Stimmung, und zwar in einer so lebendigen, wenn auch manchmal ans Chaotische grenzenden Atmosphäre, dass er selbst in eine wiederum ansteckende Begeisterung geriet. Oder es wurde, auf offenen Stationen mit grosser Bewegungsfreiheit, ein Teil der individuellen Visitengespräche ersetzt durch gemeinsame Gruppensitzungen, präsidiert durch einen nach gut schweizerischer Vereinssitte aus den eigenen Reihen gewählten Vorstand. Die Rolle des Arztes erhielt dabei auf natürlichste Weise einen kameradschaftlichen Charakter, den der junge Kollege aus seiner isolierenden Autoritätsstellung heraus suchte. Gruppen mit schwerkranken chronisch Schizophrenen kamen zustande, als die betreffenden Stationsärzte es nicht mehr aushielten, Tag für Tag die hochgradig stereotypisierten Visitengespräche mitzumachen, die Kranken dabei innerlich allein zu lassen und von ihnen ausgeschlossen zu sein. Alkoholiker und Süchtige, deren spontane Gruppierungstendenz besonders therapiefeindlich ist, klagen häufig darüber, bei den langdauernden Entziehungskuren ohne weitere Therapie in der Anstalt «versenkt» zu sein, eine Klage, die so viel ärztliches Echo findet, dass sich daraus eine Reihe von Experimenten mit Süchtigengruppen ergaben. Die therapeutischen Forderungen nach Abstinenz und disziplinierter Lebensgestaltung scheinen besser vertretbar zu sein, wenn der Arzt zum Beispiel eine gruppentherapeutische Gegenleistung für sich buchen kann und er sich den Angriffen und Klagen in einer Therapiegruppe stellt.

Hauptsächlich von den Bedürfnissen der Krankenstation und des Pflegepersonals her diktiert ist die sogenannte Notfallindikation zur Gruppentherapie bei besonders therapieresistenten Kranken. Eine hysterische Psychopathin beispielsweise war trotz individueller Psychotherapie und intensiver Sedierung nicht zu beruhigen und provozierte ihre Umgebung durch ungehemmtes Gefluche und Zerschmettern von Blumentöpfen. In einer Therapiegruppe mit anderen psychopathischen Mädchen agierte sie zwar unvermindert weiter, aber auf der Station kehrte Ruhe ein und die

Patientin wurde entlassungsfähig. Umgekehrt verwandelte sich ein unintelligenter Schimpfer und Querulant in einen umgänglichen und höflichen Mann, als er in eine Frauengruppe versetzt wurde.

Aus einer ganz anderen Region stammen die Motive des therapeutischen Ehrgeizes und des wissenschaftlichen Interesses. Gruppentherapeutische Belange werden im Burghölzli seit Jahren referiert und diskutiert. Das Interesse an der verborgenen Dynamik und Kommunikationsfähigkeit scheinbar dementer Schizophrener beflügelte zum Beispiel die ersten gruppentherapeutischen Versuche auf den Stationen für Chronisch-Kranke. Die Absicht, Theorien über schizophrenogenes Elternmilieu nachzuprüfen, war ebenso stark wie der Wunsch, die Angehörigen zu beraten, als bifokale Gruppen im Sinne RAOUL SCHINDLERS eingeführt wurden. Anregungen und Erwartungen des Klinikdirektors stimulierten ebensooft, wie das Bedürfnis des Therapeuten, sich selbst eine Eignung zur Gruppentherapie zu beweisen. Anteilnehmende Neugier, tiefer in den Kranken und sein Leiden einzudringen, kann stärker sein als eigentlich therapeutischer Helferwille. Interesse an der Gruppendynamik mag grösseres Gewicht haben, als die Überzeugung, den Patienten eine spezifische therapeutische Möglichkeit anzubieten.

In Ansätzen sind auch Motive mehr persönlicher Art sichtbar geworden. So fühlt sich der eine Therapeut weniger belastet und besser geborgen in der Gruppe als in der Einzeltherapie; eine Art «Stallwärme» erleichtert es ihm, jene Haltung zu finden, die ihm selbst heilsam ist und etwas Heilsames ausstrahlen kann. Umgekehrt kennen wir den Therapeuten, der daran leidet, sich in einer Gruppe unbehaglich zu fühlen und um den Verlust seiner gewohnten Absicherungen zu fürchten; dieses Leiden veranlasst ihn, die «Gefahr» zu suchen, was ihm in der Therapiegruppe aus der relativen Sicherheit der leitenden Position heraus eher gelingt als anderswo.

Zweierlei hat uns an den hier angedeuteten Ergebnissen vor allem überrascht. Zunächst ist nicht zu übersehen, dass das eigentliche therapeutische Interesse am einzelnen Kranken nicht im Vordergrund steht, und schon gar nicht im Sinne therapeutischer Erwartungen, die sich aus einer Theorie der Gruppendynamik begründen liessen. Vielmehr scheint es dem Arzt darum zu gehen, jene therapeutische Haltung und Rolle zu suchen, mit der er seinen Aufgaben als Anstaltsarzt gerecht werden kann. Und hier stehen wir vor der zweiten überraschenden Tatsache. Obwohl die psychotherapeutische Ausbildung unserer Ärzte hauptsächlich psychoanalytisch ausgerichtet ist, verschiebt sich das Schwergewicht unserer Gruppentherapien immer mehr von den analytischen Gruppen weg zu

nicht analytisch geführten – wenn auch unter analytischen Gesichtspunkten kontrollierten – Aussprache- und vor allem Aktivitätsgruppen. Obwohl unser Ehrgeiz und unsere Begeisterung anfangs der analytisch deutenden Gruppenarbeit galten, erwiesen sich der therapeutische Effekt oft als gering und analytische Erwartungen als unangebracht. Eine Erklärung sehen wir am ehesten darin, dass in einer Anstalt, die ihre Patienten nicht auswählt, die Mehrzahl der Kranken durch eine analytische Therapie überfordert wird, eine Erfahrung, die auch für die Einzeltherapie gilt. Die Hoffnung darauf, das Krankhafte mit dem Patienten durcharbeiten zu können, bleibt zu oft unerfüllt und wird abgelöst durch die Tendenz, in Aktivitätsgruppen die gesunden Kräfte des Patienten anzusprechen und zu fördern. Eine Stimmung des Vertrauens lässt sich hier rascher und intensiver entwickeln als in der analytisch geführten Gruppe. Unseren Patienten angemessener und dadurch für alle Teile befriedigender wurden Gruppen wie administrative Abteilungskonferenzen, wo die Patienten selbst über ihre alltäglichen Belange entscheiden, Abteilungsparlamente, Ferienlager mit Chronisch-Kranken, Beschäftigungstherapiegruppen, Zeichnungsgruppen, Clubabende für Klinikentlassene (wozu auch Hospitalisierte eingeladen werden) und anderes mehr. Drastisch einleuchtend war beispielsweise der folgende Fall:

In einer analytisch geführten Neurotikergruppe brachten eine depressive Hausfrau und ein querulatorischer Charakterneurotiker die Arbeit durch ihr massives Abwehrverhalten während eines vollen Jahres zum Scheitern. Kaum in den Club für Entlassene aufgenommen, zeigten sie hervorragende Qualitäten: die Hausfrau entfaltete ihre Mütterlichkeit in der liebevollen Betreuung unbeholfener Patienten, und der Charakterneurotiker fand sich in die animierende Rolle des geistreichen Causeurs und Conférenciers.

Es ist offensichtlich, dass dieser Erfolg gewissermassen auch einen therapeutischen Verzicht darstellt. Verzicht ist aber nicht gleichbedeutend mit Resignation; die Erreichung eines begrenzten Ziels ist vor allem dann wertvoller als das fortgesetzte Scheitern an einem «höheren» Ziel, wenn dieses Scheitern auch die bescheideneren Ziele verpassen lässt.

Wir fragten uns weiter, wie weit die geschilderten Motive auch die Indikationsstellung zur Gruppentherapie und die Auswahl der Patienten zu beeinflussen vermögen. Ein Vergleich gab uns Auskunft. Gruppentherapeuten, die gleichzeitig auch Stationsärzte sind, wählen ihre Patienten anders aus als Kollegen, die nicht für Atmosphäre und Funktionieren einer Station verantwortlich sind und die es sich eher leisten können, ihre Patienten nach Eignung und prognostischen Chancen auszusuchen.

Was für Schlussfolgerungen sollen wir daraus ziehen? Soll man dem Stationsarzt von der Gruppentherapie abraten? Ihm seine Motive schlecht machen? Wir halten das Gegenteil für richtig. Aus eben diesen Motiven hat ein grosser Teil unserer Gruppenarbeit eine Wandlung erfahren, die wesentlich zur Schaffung einer vertrauensvollen und therapiefreundlichen Stimmung auf unseren Krankenstationen beitrug. Eben diese Motive halfen uns, das beziehungslose Nebeneinanderlaufen von Psychotherapie und klinischem Alltag in der Anstalt zu korrigieren. Und dieselben Motive bewahrten uns davor, kritiklos an der faszinierenden Methode analytisch deutender Gruppentherapie festzuhalten, statt unsere Arbeit den Möglichkeiten und Bedürfnissen unserer Patienten anzupassen.

Dem erfahrenen Kliniker und klinischen Therapeuten sind diese Verhältnisse geläufig; er wird aus diesen Zeilen kaum etwas Neues erfahren. Für den jungen Anstaltsarzt hingegen, der in der analytischen Ausbildung steht, können diese banalen Dinge verwirrend sein. Aus der individuellen Analyse stammende therapeutische Erwartungen können kollidieren mit einer Patientenauswahl, die den geschilderten Motiven folgt. Der Kollege beispielsweise, der die schon genannte Gruppe psychopathischer Mädchen führte, verzweifelte fast angesichts der massiv ausagierten Widerstände in der Gruppe, obwohl sein eigentliches Motiv durch die bessere Anpassung der Patientinnen auf der Krankenstation zweifellos gerechtfertigt war.

Wir kommen damit zur letzten Frage: Soll die analytische Ausbildung der Kollegen ergänzt werden durch eine Einführung in nicht analytisch deutende Gruppenarbeit? Und handelt es sich bei der nicht analytisch deutenden Gruppenarbeit eigentlich noch um eine ärztliche Aufgabe? Um hinten anzufangen: Beschäftigungstherapeutinnen können zum Beispiel bessere Voraussetzungen haben zur Gestaltung erfolgreicher Gruppen als Ärzte. Und Ärzte ohne psychotherapeutische Ausbildung und psychiatrische Ambitionen können unter Umständen überzeugender und lebendiger wirken als ein allem Agieren abholder, in der Kunst des therapeutischen Versagens geübter Analytiker. Und trotzdem steht es für uns ausser Frage, dass die Beteiligung der Anstaltsärzte an den Gruppenaktivitäten und eine analytische Ausbildung eines Teils der Ärzte unbedingt erforderlich ist, wenn die therapeutische Haltung der Ärzte und die Behandlungsbereitschaft der Patienten nicht Schaden leiden sollen. Das muss nicht heissen, dass in der Ausbildung die analytische Gruppenarbeit der nichtanalytischen vorauszugehen habe, im Gegenteil. Beispiele von Kollegen, die über anfängliche Schwierigkeiten der analytisch deutenden Gruppentherapie nicht hinauskamen und die sich später auch unter besse-

ren Voraussetzungen nicht mehr an diese Aufgabe heranwagten, sind uns eine eindringliche Mahnung. In die Führung von Aktivitätsgruppen kann man sich gefahrloser einarbeiten. Eine systematische Schulung scheint dabei nicht erforderlich und vielleicht nicht einmal erwünscht zu sein, da beim Festhalten an einer als Theorie formulierten Methode mehr Spontaneität verlorengehen als gewonnen werden kann. Eine Art Pionierbewusstsein hat zum Gelingen vieler unserer Gruppen beigetragen. Regelmässige Kontrollsitzungen und Diskussionsstunden unter Gruppentherapeuten, wobei die Klärung der Motivation nicht zu kurz kommen sollte, sowie Selbsterfahrungsgruppen haben sich hingegen unter unseren Verhältnissen gut bewährt.

Zusammenfassung

Anhand der Erfahrungen mit rund 30 Therapiegruppen in der Psychiatrischen Klinik Burghölzli werden die Motive disktuiert, die zur Bildung solcher Gruppen führen. Rücksichten auf die Erfordernisse der Krankenstationen sowie das Bedürfnis des Arztes nach einer angemessenen therapeutischen Rolle sind massgeblich daran beteiligt, wie an einigen Beispielen gezeigt wird. An einer Klinik ohne Patientenauslese lässt sich diesen Motiven oft eher gerecht werden in Aktivitätsgruppen als in eigentlich analytisch deutenden Gruppen. Im Rahmen einer analytisch orientierten, durch Kontrollbesprechungen und Selbsterfahrungsgruppen unterstützten Ausbildung sind Aktivitätsgruppen gut geeignet zur Einführung in die Gruppenarbeit.

Summary

Experience with about thirty therapeutic groups in the Burghölzli Psychiatric Hospital is adduced to illustrate the motives leading to the formation of such groups. Considerations of requirements of the wards and the psychiatrists' need for an adequate therapeutic role play a decisive part, as some examples show. In a hospital with an unselected intake of patients, the motives can often more easily be taken into account in activity groups than in analytically interpreting groups. Activity groups from a good introduction to group work within the framework of analytically oriented training, supported by supervisory discussion and exploratory groups.

Adresse der Autoren: Dr. P. PETERSEN, Psychiatrische Klinik der Medizinischen Hochschule, Podbielskistrasse 380, *D-3 Hannover* (Deutschland) und Dr. Dr. A. UCHTENHAGEN, Lenggstrasse 31, *CH-8008 Zürich* (Schweiz).

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Soziometrische Position und Gesprächsverhalten in stationären Männer- und Frauengruppen

A. PLOEGER und P. SCHLUNK

Universitätsnervenklinik Tübingen
(Direktor: Prof. Dr. W. Schulte)

Wir berichten von einer Untersuchung aus der Psychotherapieabteilung der Universitätsnervenklinik Tübingen, in der Einzel- und Gruppenpsychotherapie im Sinne der *therapeutischen Gemeinschaft* angewendet wird. Die Abteilung besteht aus einer Männer- und einer Frauenstation mit je vierzehn Patienten. Wöchentlich einmal wird innerhalb der Männer- und der Frauenstation ein soziometrischer Test mittels Fragebogen durchgeführt, auf dem die Patienten den «am nächsten» und den «am entferntesten» stehenden Mitpatienten notieren. Die graphische Auswertung aller Wahlen für jede der beiden Gruppen (das Soziogramm) ergibt eine Rangabstufung der Beliebtheit, die wir nach der Anzahl der positiven (ersten) und der negativen (zweiten) Wahlen in vier Positionen aufteilen: «Beliebte» nennen wir Patienten in Positionen mit nur oder weit überwiegend positiven, «Unbeliebte» oder «Abgelehnte» Patienten mit nur oder weit überwiegend negativen Wahlen. Unter «nicht Beachtete» verstehen wir Patienten, die keine Wahl erhalten, während die «ambivalent Gewählten» ebensoviel positive wie negative Stimmen auf sich vereinen. Ausserdem werden «nicht Einstufbare», d. h. solche Positionen registriert, die in keine dieser Kategorien passen. Im Gegensatz zu der ähnlichen Einteilung von SCHINDLER [1957] meinen wir mit den Positionen noch keine bestimmte Funktion innerhalb der Gruppe. Wir möchten vielmehr mit dieser Rangreihe zunächst nur eine quantitative Abstufung der Wahlen bezeichnen.

Im Zuge der soziometrischen Analysen untersuchten wir u. a. die drei folgenden Fragen:

1. Besteht ein signifikanter Unterschied in der Verteilung der einzelnen Positionen zwischen der Männer- und der Frauengruppe? Bei 199 Einstu-

fungen in der Männer- und 194 in der Frauengruppe ergab sich Folgendes (Abb. 1):

Die Männer- und die Frauengruppe unterscheiden sich hochsignifikant in der Verteilung der fünf soziometrischen Positionen (χ^2-Test)[1]: Während die Frauengruppe sich häufiger in den affektiv klar definierten Positionen «Beliebte», «Unbeliebte» und «nicht Beachtete» einstufte, waren die Männer häufiger in den Positionen «ambivalent Gewählte» und «nicht Einstufbare» zu finden. Dies scheint darauf hinzuweisen, dass sich in der Frauengruppe eine Hierarchie nach Gefühlsabstufung von «Beliebten» über «nicht Beachtete» zu «Abgelehnten» ausbildet. In der Männergruppe sprach der hohe Prozentsatz in den Positionen «ambivalent Gewählte» und «nicht Einstufbare» gegen eine solche rangmässige Gliederung. Männliche Patienten gaben sich demnach öfter gegenseitig Positionen, die weder Beliebtheit noch Zurückweisung bedeuteten. Dies statistische Ergebnis stimmt mit früheren Beobachtungen [PLOEGER, 1964 b] überein.

2. Wöchentlich zweimal werden in der Abteilung therapeutische Gruppengespräche abgehalten, einmal in homogenen Männer- und Frauengruppen, das andere Mal in gemischten Gruppen. Im Beobachtungszeitraum von acht Monaten nahmen durchschnittlich acht Patienten an einem Gespräch teil, ausserdem meist zwei Therapeuten und ein Beobachter.

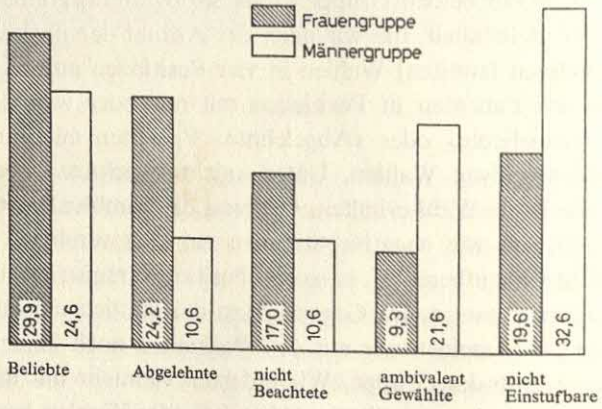

Abb. 1. Verteilung der fünf soziometrischen Positionen bei 199 Einstufungen in der Männergruppe und 194 in der Frauengruppe. Zum direkten Vergleich sind Prozente angegeben.

[1] Bei der statistischen Auswertung richteten wir uns nach MITTENECKER [1966].

Die Gespräche wurden auf Tonband aufgenommen und anschliessend im vollen Wortlaut mit Schreibmaschine übertragen und dann nach dem Kategoriensystem von BALES [1951] für Gruppeninteraktionen ausgewertet.

Das Kategoriensystem von BALES [1951]

A. Sozial-emotionaler Bereich, positive Reaktionen
   1. *Zeigt Solidarität,* bestärkt den anderen, hilft, belohnt.
   2. *Entspannt Atmosphäre,* scherzt, lacht, zeigt Befriedigung.
   3. *Stimmt zu,* nimmt passiv hin, versteht, stimmt überein, gibt nach.

B. Aufgabenbereich, versuchte Antworten
   4. *Macht Vorschläge,* gibt Anleitung, wobei die Autonomie des anderen impliziert ist.
   5. *Äussert Meinung,* bewertet, analysiert, drückt Gefühle oder Wünsche aus.
   6. *Orientiert,* informiert, bestätigt, wiederholt, klärt.

C. Aufgabenbereich, Fragen
   7. *Erfragt Orientierung,* Information, Wiederholung, Bestätigung.
   8. *Fragt nach Meinungen,* Stellungnahmen, Bewertungen, Analyse, Ausdruck von Gefühlen.
   9. *Erbittet Vorschläge,* Anleitung, mögliche Wege des Vorgehens.

D. Sozial-emotionaler Bereich, negative Reaktionen
   10. *Stimmt nicht zu,* zeigt passive Ablehnung, Förmlichkeit, keine Hilfe.
   11. *Zeigt Spannung,* bittet um Hilfe, zieht sich zurück.
   12. *Zeigt Antagonismus,* setzt andere herab, verteidigt oder behauptet sich.

Als Interaktionseinheit wählten wir entsprechend BALES [1951] die «kleinste Einheit des Verhaltens, die ihrem Inhalt nach so vollständig ist, dass sie vom Beobachter gedeutet werden kann oder im Gesprächspartner eine Reaktion hervorruft». Da die Patienten sowohl am homogenen wie am gemischten Gruppengespräch teilnahmen, stellten wir uns die zweite Frage, *ob sich unter diesen verschiedenen Bedingungen die Interaktionsprofile verändern (Vergleich zwischen dem Verhalten beim homogenen und beim gemischten Gruppengespräch).* Auch diese Untersuchungen wurden für Männer und Frauen getrennt durchgeführt. Die Interaktionsprofile von Protagonisten und Patientengesprächsleitern [vgl. PLOEGER, 1965] haben wir nicht berücksichtigt, um nur die spontanen Interaktionen zu erfassen, die nicht aus der Verpflichtung für eine bestimmte Rolle erwachsen. Insgesamt nahmen 22 Männer und 24 Frauen (Aufenthaltsdauer in der Abteilung durchschnittlich acht Wochen) an beiden Gesprächsarten teil. Mit dem Wilcoxon-White-Test konnte nachgewiesen

werden, dass sich das Interaktionsprofil des einzelnen Patienten in signifikanter Weise ändert, wenn er statt am homogenen am gemischten Gruppengespräch teilnahm. Dabei sprachen und erhielten die männlichen Patienten beim Gespräch in der gemischten Gruppe in signifikanter Weise insgesamt mehr Einheiten als in der reinen Männergruppe. Im Vergleich zu den anderen Kategorien der Bales-Skala machten sie in der gemischten Gruppe, also in Gegenwart von Frauen, mehr Vorschläge und fragten öfter nach Orientierung als in der reinen Männergruppe. Die Frauen dagegen sprachen in der gemischten Gruppe insgesamt weniger als in der Frauengruppe. Sie äusserten ihre Meinung seltener in der gemischten Gruppe, also in Gegenwart von Männern.

Diese hier in Deutschland gewonnenen Ergebnisse stehen im Gegensatz zu Erfahrungen, die GUGGENBÜHL-CRAIG [1956] in den USA machte. Sie bestätigen andererseits statistisch schon früher mitgeteilte Verhaltensbeobachtungen [PLOEGER, 1964 b].

3. Mit der dritten Frage suchten wir eine *Verbindung zwischen der soziometrischen Position und dem Verhalten im therapeutischen Gruppengespräch, wie es sich in der Bales-Skala manifestiert, aufzufinden.* Dazu wurden die Interaktionsprofile von Patienten verschiedener soziometrischer Positionen verglichen. Es konnten nur die Profile von den Patienten verwendet werden, welche am homogenen Gruppengespräch teilgenommen hatten und die nicht als Gesprächsleiter oder Protagonisten fungierten, weil ja auch die soziometrischen Tests nur innerhalb der Männer- bzw. Frauengruppe durchgeführt werden, und um wiederum nur die spontanen Interaktionen zu erfassen. So konnten 34 Profile von Beliebten, 28 von Abgelehnten, 20 von nicht Beachteten und 21 von ambivalent Gewählten miteinander verglichen werden. Die nicht Einstufbaren wurden hier nicht berücksichtigt.

Im Gegensatz zum Vorgehen unter Frage 1. und 2. wurden hier Frauen und Männer gleicher soziometrischer Position zusammengefasst, da sich ihre Interaktionsprofile nicht signifikant unterschieden (exakter Fisher-Test). Die Unterschiede zwischen den Interaktionsprofilen der vier genannten soziometrischen Positionen wurden mit dem Mann-Whitney-Test für jede einzelne Kategorie der Bales-Skala geprüft. Dabei fanden sich zwischen den Profilen der «nicht Beachteten» und der «ambivalent Gewählten» keine signifikanten Unterschiede. Beliebte und nicht Beachtete waren nur in der Kategorie Nr. 9 = «erbittet Vorschläge» verschieden. Beim Vergleich der Interaktionsprofile von Beliebten und Abgelehnten zeigten sich folgende signifikanten Unterschiede: Die Abgelehnten

sprachen und empfingen insgesamt mehr Einheiten als die Beliebten. Sie stimmten häufiger zu, brachten mehr Vorschläge, Meinungen und Informationen, fragten öfter nach Meinungen und Vorschlägen und zeigten mehr Spannung als Patienten in einem höheren soziometrischen Rang. Auch zwischen Abgelehnten und nicht Beachteten bestanden in mehreren Kategorien signifikante Unterschiede, wobei die Abgelehnten höhere Interaktionsraten hatten.

Interpretationen hierzu können nur vermutungsweise gegeben werden: MORENO [1954] und HURWITZ [1954] halten es geradezu für ein Charakteristikum des Menschen im niederen soziometrischen Rang, dass er wenig spricht. Auch BATES [1952] fand, dass ein hoher sozialer Rang mit einer hohen Interaktionsrate positiv korreliert war. Im gleichen Sinne konnten FESTINGER und KELLEY [1951] zeigen, dass die Gruppenmitglieder dahin tendierten, mit dem Beliebten zu interagieren. All diese Befunde scheinen zunächst im Widerspruch zu unseren Ergebnissen zu stehen. Dazu ist zu sagen, dass sich unsere Untersuchungen nur auf die Situation des therapeutischen Gruppengesprächs beziehen und nicht ohne weiteres für Gruppen allgemein gelten.

Einen Hinweis für die Interpretation unserer Ergebnisse fanden wir bei FESTINGER und KELLEY [1951] [zit. nach HORWITZ, 1953, p. 315]. Danach verhielt sich die Frequenz der Interaktionen umgekehrt zur Beliebtheit, wenn die Interaktionen *unangenehm* waren. Da es bei analytisch orientierter Führung eines Gruppengespräches um die Erhellung inkompatibler Regungen geht und weil in den mehr psychagogisch verlaufenden Gruppengesprächen der einfacher strukturierten Patienten häufig eine Scheu vor der vermeintlichen «Preisgabe» von persönlichen Problemen aufkommt, möchten wir annehmen, dass die Interaktionen in jedem therapeutischen Gruppengespräch, wie wir es führen, für die Mitglieder tatsächlich überwiegend «unangenehm» sind. Aus diesem Grunde beobachten wir ja auch des öfteren Widerstandsphänomene in Form von Schweigen oder der Wahl unpersönlicher Themen. Unsere Ergebnisse würden insofern mit FESTINGER und KELLEY [1951] übereinstimmen.

In der Situation unserer stationär-klinischen Abteilung bietet sich aber noch eine andere Erklärung an: Das Soziogramm ist der Niederschlag aller Anziehungen und Abstossungen, die sich im Laufe des Zusammenlebens der Patienten während des ganzen Tages ergeben. Unsere Interaktionsprofile sagen aber nur etwas über das Verhalten in der Situation des zweimal wöchentlich stattfindenden Gruppengespräches aus. Obwohl die «therapeutische Gemeinschaft» [JONES, 1953], wie wir sie anstreben, die

Gleichrangigkeit aller Mitglieder einschliesslich der Ärzte in der «offiziellen Gruppenstruktur» voraussetzt [PLOEGER, 1964a], dürfte sich die Anwesenheit des Arztes bei den therapeutischen Gruppengesprächen auf das Verhalten in den verschiedenen soziometrischen Positionen auswirken. Wenn sich die Patienten zum Gruppengespräch treffen, bringen sie gleichsam ein fest gefügtes Netz affektiver Verbindungen mit, das aus den gegenseitigen Erfahrungen und Übertragungen im Zuge des Stationslebens resultiert und in dem jeder Patient seinen Platz hat. Wahrscheinlich wird durch das Hinzukommen des Therapeuten im Gruppengespräch das Verhaltensmuster, das die Gruppe unter sich hat, schon insgesamt verändert. Es kann sein, dass die Abgelehnten diese situative Lockerung durch lebhafteres Agieren in dem Bestreben nutzen, im Schutze des Therapeuten ihren Rang zu verbessern. HURWITZ, ZANDER und HYMOWITCH [1954] halten es in ähnlichem Sinne für möglich, dass die verstärkte Kommunikation ganz allgemein ein Mittel ist, die Angst um den Verlust des Status zu verringern.

Schliesslich müssen wir noch die umgekehrte Erklärung offenlassen, dass nämlich eine habituell erhöhte Aktivität ihrerseits erst die Ablehnung mitbegründet, weil sie die Mitpatienten in ihrem Aktionsradius einengt.

Zusammenfassung

Bei der allwöchentlichen Soziometrie in einer klinischen Psychotherapiestation für Männer und in einer für Frauen wurden fünf Positionen unterschieden: Beliebte, Unbeliebte oder Abgelehnte, nicht Beachtete, ambivalent Gewählte und nicht Einstufbare. Untere anderem ergab sich:

1. Die affektiv klar definierten Positionen (Beliebte, Abgelehnte und nicht Beachtete) wurden in der Frauengruppe hochsignifikant häufiger gewählt als in der Männergruppe. Dies sprach dafür, dass sich in der Frauengruppe eine wesentlich stärkere Hierarchie nach Gefühlsabstufung ausbildet als in der Männergruppe.
2. Beim geschlechtlich gemischten Gruppengespräch interagierten die männlichen Patienten signifikant mehr (nach der Bales-Skala) als im reinen Männer-Gruppengespräch. Insbesondere machten sie mehr Vorschläge und fragten öfter nach Orientierung. Die Frauen dagegen sprachen in der gemischten Gruppe weniger als in der reinen Frauengruppe und äusserten ihre Meinung seltener.

3. Beim Vergleich der soziometrischen Positionen mit den Interaktionen im therapeutischen Gruppengespräch ergab sich u. a.: Abgelehnte interagieren signifikant mehr als Beliebte und Unbeachtete. Dieses Ergebnis bei unseren Psychotherapiegruppen steht im Gegensatz zu den Feststellungen anderer Autoren, dass bei Gruppen im allgemeinen die Beliebtesten am meisten interagieren. Schon FESTINGER und KELLEY [1951] bemerkten jedoch eine Umkehr der Interaktionsraten, wenn die Interaktionen unangenehm waren. Wir nehmen an, dass die Interaktionen in therapeutischen Gesprächs-Gruppen, im Gegensatz zu Gruppen im allgemeinen, wegen des psychotherapeutischen Widerstandes tatsächlich vorwiegend unangenehm sind. Es besteht noch eine andere Erklärungsmöglichkeit: Die Abgelehnten nutzen das Gruppengespräch in dem Bestreben, im Schutz des hierbei anwesenden Therapeuten durch lebhaftes Agieren ihren Rang zu verbessern. Schliesslich bleibt noch offen, ob nicht umgekehrt eine habituell erhöhte Aktivität erst die Ablehnung begründet, weil sich die Mitpatienten dadurch eingeengt fühlen.

Summary

Weekly sociometric study in a psychotherapy department for male and another for female in-patients revealed five positions: liked, disliked or rejected, unnoticed, ambivalent choice and unclassifiable. Results:

1. The positions with clearly defined affect (liked, rejected and unnoticed) were significantly more often chosen in the women's group than the men's. This suggests that a much stronger emotional hierarchy was formed in the female than in the male group.

2. In mixed discussion groups, the male patients interacted significantly more (according to the Bales scale) than in the all-male group. In particular, they more often made suggestions and asked for advice. The women, on the contrary, spoke less in the mixed group than in the all-female group and gave their opinion less often.

3. When the sociometric positions were correlated with the number of interactions, it was found that rejected individuals interacted significantly more than liked or unnoticed. This experience in our psychotherapy groups is in disagreement with that of other authors that in general the most liked in a group interact most. FESTINGER and KELLEY observed however that the rate of interaction was reversed when the interactions were unpleasant. We assume that interactions in a therapeutically oriented

discussion group, unlike groups in general, will tend in fact to be unpleasant because of the psychotherapeutic resistance. There is, however, another possible explanation: rejected individuals take the opportunity of the group discussion to improve their 'rank', under the protection of the therapists presence, by interacting vigorously. Finally the opposite possibility remains, that a habitual high rate of activity is itself the reason for dislike, as the other patients feel themselves constricted.

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Adresse der Autoren: Dr. med. Dipl. Psych. A. PLOEGER und cand. med. P. SCHLUNK, Universitätsnervenklinik, Osianderstrasse 22, *D-74Tübingen* (Deutschland).

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Comprehensive Approach in a Child Guidance Clinic

H. N. KOHN, Passaic, N. J. and H. L. CHODOSH, Paterson, N. J.

Introduction

This paper describes a study made with the attempt to deal with the problems of the disturbed child by using a comprehensive approach. By utilizing the combined facilities of a general hospital, a child guidance clinic and a clinic for the retarded, it was tried to make a full diagnosis of each patient's problems and to apply the most effective methods of management.

The usual child guidance team consisting of psychiatrist, psychologist and psychiatric social worker made initial evaluations of the children, who were referred mainly for behavior problems, poor school performance or psychosomatic complaints. When organic illness, such as cerebral palsy, epilepsy or other brain damage were suspected, a pediatric examination was requested and metabolic, x-ray and neurological examinations were done. For the latter, not only routine tests were used, such as reflexes, gross motor and sensory responses, but also some more accurate tests were included, suggested by L. BENDER and associates and referred to as 'soft neurological signs' [POLLACK and KRIEGER, 1958] (see Appendix, p. 173 and table I).

Table I. Soft neurological signs

EEG	Clearly positive	some positive	negative	Total
Abnormal	11	21	12	44
Minimal abnormal	14	20	20	54
Normal	5	15	17	37
Total	30	56	49	135

Methods and material

Electro-encephalograms were done where preliminary examinations showed any of the following:

History of convulsions, trauma, brain damage; mental retardation; positive neurological findings; severe emotional disturbance; discrepancies between physical findings, history and severity of symptoms; suggestion of organicity in psychological tests.

Neurological examinations and concurrent electro-encephalograms (EEG) were performed on a consecutive series of 135 children evaluated for services.

Findings

Neurological tests for soft signs were abnormal in 86 (63.7 %). About $^1/_3$ of them showed major, $^2/_3$ minimal abnormality.

EEGs showed obnormalities in 98 (72.9 %), about 40 % with moderate or severe abnormality, 60 % minimally abnormal.

EEGs were abnormal in 75.7 % of the patients with abnormal neurological signs, versus 72.9 % of all cases.

Neurological abnormalities were found in 67.3 % of the patients with abnormal EEGs, versus 63.7 % of all cases.

Of the 135 children 66 or 48 % showed abnormalities in both the neurological tests and in the EEG, while 17 or 13 % were normal in both respects.

It appears that disturbed behavior can be associated either with abnormal EEGs or with abnormal neurological findings or both. Since the EEGs were usually requested when there was some degree of suspicion of organicity, the tests obviously were not performed on a random sampling of patients.

It is of interest that there existed a close correlation between behavior disorders, abnormal EEGs and the presence of minimal or 'soft' neurological signs. Numerous authors have described a high incidence of abnormal EEGs in children with behavior disorders, mainly in hyperkinetic and impulsive children, the tracings frequently characterized by bisynchronous paroxysmal activity.

In view of the experiences herein described, it seems probable that the thoroughness of the neurological screening may alter the diagnostic concept, so that the term 'primary behavior disorder' may be based on different criteria among various workers. The importance of the high correlation of neurological and EEG abnormalities lies in the observation that these organic factors may be overlooked easily, were it not for the inclusion of a thorough medical examination in the evaluation. The significance

of any such deficit is obvious, particularly in terms of the total planning for the patients, interpretation to the parents and proper delineation of treatment goals.

Therapeutic interpretation of the clinical findings

Once a diagnostic conclusion was reached, using the comprehensive approach described above, the next step was interpretation of the results to the parents in terms of practical management. The psychiatrist on the clinic team provided a general orientation concerning the factors which were seen as responsible for the child's disturbance. At this point factual advice or instruction was less emphasized than the fact that treatment was indicated, and the manner in which it could be structured. Predictions were avoided and the initiative to start treatment was left with the family.

The following question inevitably arose: 'Is there something wrong with my child?' It was considered extremely important to handle this question constructively, interpreting the essential factors in a non-threatening way. This was particularly important where the parents were anxious, fearing that the exceptional child would always remain so or would get worse and perhaps bring social and financial ruin upon the family.

An attempt was always made to point out essential factors of personal interaction among the family members, with stress on the potential for growth and development. This frequently made the difference between discouragement and cooperation. Even where physical findings were abnormal, it was found justifiable to follow these lines. The explanation of an abnormal EEG was often difficult, particularly when there was not a certainty of its full significance.

It was most important to see the child in his total functioning and to estimate the significance of the various laboratory tests. Then an attempt was made to appreciate how much of the disturbed behavior was determined by the organic dysfunction, hyperirritability, impulsivity and poor coordination. Although a diagnosis of brain damage is not made on an EEG alone, dysfunction may also be evident in the other tests and may be one contributory factor to poor performance or disturbed behavior. The major cause of the maladjustment, however, may be the poor understanding of the child's needs by the family or their inability to meet the demands which are greatly increased by the organic malfunction. For example, the child may not respond to normal expressions of affection by the parents and may frustrate them to the point of rejection. This is usually

a gradual process that gets worse, unless it can be reversed by guidance of the family.

The therapeutic interpretation of the findings implied the clarification of the emotional and physical factors. The psychiatrist presented the formulation, indicating that the process of fact finding was not an attempt to put the blame on anyone, but rather an observation that there were several or many factors involved, and that treatment would help to modify as many as possible.

Where the parents were defensive, the mention of physical defects sometimes was grasped eagerly and made the center of their anxieties and resistances. The therapist, aware of the multiplicity of causes, was able to point out to them that there are disabilities and handicaps in many children with normal behavior, and that the abnormal findings did not necessarily mean epilepsy, mental illness, or disaster. He then explained that this was another aspect of the problem, where accessory treatment, perhaps by drugs, could be applied. It was as important to relieve excessive anxiety as it was to avoid undue optimism and complete reliance on drugs.

The explanation of medical findings was given by the medical staff. Parents often expected to obtain facts and figures which they were really unable to use. In those cases where the EEG showed a clearly convulsive pattern, medication and the general outline of management as well the prejudices and the frightening misconceptions about epilepsy were discussed.

Where the EEG findings were minimal, signifying immaturity rather than definite abnormality, the parents were told that the pattern was likely to improve, that however the child at this point had a physical cause for the malfunction. A repeat was advised after about one year. Medication was indicated where the behavior of the child requested treatment, in addition to counselling.

The interpretive interview usually elicited a response consistent with the overall attitudes of the parents. Overanxious parents were prone to enlarge the issue, and rejecting parents used the information against the child. Full cooperation on the part of the parents after one or a few interviews was not always expected, but their response was considered significant as to their attitudes and was managed as such. In this respect the sharing of the diagnosis had therapeutic potential and was utilized accordingly.

Treatment procedures

Therapeutic suggestions followed three main categories: 1. psychotherapy, 2. drug therapy and 3. environmental manipulation.

1. Psychotherapy

The children were seen individually or in groups once weekly, in severe cases twice, usually for several months to several years. At least one of the parents was seen also, usually in a group. Parents with severe problems were also seen individually, or were encouraged to seek more intensive treatment elsewhere. The principles of treatment followed psycho-analytic guide lines. Sometimes additional emphasis was placed on physical and environmental aspects.

2. Drug therapy

Drugs were used according to individual needs, not routinely, and not, when there was resistance. A recommendation for medication was made in about 30 % of the cases including those who had been on medication when referred to the clinic. As a rule, recommendation for drugs was made to the family physician, and only where this was not feasible, did the clinic prescribe and supervise the medication. Main indications for drug therapy were:

known epilepsy,
brain damage with behavior disturbance,
acting out or anxiety beyond tolerance.

The therapists were aware that the use of drugs could interfere with the treatment relationships. Thus they took care to point out to the parents und wherever feasible to the children, that the use of drugs was only one accessory measure to help them over a difficult period, but was not the treatment itself. The action of the drugs was explained and misconceptions corrected.

In those cases where prompt relief of anxiety or improvement of aggressive behavior could be obtained, the strained relations within the family were eased, permitting them to take a fresh look at the situation. Those who failed to continue at this point had often made some gains with the result that they were more interested in seeking treatment whenever difficulties came up again.

Regarding the choice of drugs, the EEG was a guide, although not fully specific. In paroxysmal patterns anticonvulsive drugs were tried first, beginning with phenobarbital. This often was increasing the restlessness. In many cases phenothiazines, meprobamate, and amphetamine were found

useful, singly or in mixtures. Diphenhydramine was effective in quieting hyperactive younger children.

3. Environmental management

Close cooperation with the personnel of schools and other agencies was obtained through discussions and reports whenever needed and only with the express consent of the parents. The clinic's function was strictly advisory. Conferences with teachers, principals, guidance counselors, camp counselors and others were held to clarify the child's needs and to possibly modify a program that was not suitable for him; pressure was never applied to force a difficult child on a teacher or into a class program. In the management of a hyperactive child we first suggested tranquilizers. If several trials proved unsuccessful, plans were made to have the child attend school or kindergarten for one or a few hours only, relying on the teacher's judgment and extending the periods, when this was advisable. In this way the cooperation of the teachers was stimulated and in many cases the child adjusted to the routine soon and could return to a full schedule.

In similar ways discussions with probation officers were held in a realistic spirit and with the intent to develop rehabilitation plans. Where continuous supervision or detention was required, suggestions for psychiatric help for children and parents were offered.

Conclusions

The use of comprehensive studies in a child guidance clinic confirmed the observation that the present etiologic classification of childhood disturbances rarely does full justice to the situation. We found, that in the majority of cases endogenous factors are in constant and complex interplay with familial, social and cultural factors. A case in which the behavior disturbance seems clearly based on a disturbed environment can present new aspects after a thorough physical study, and obviously cases with gross organic damage, like post-encephalitic disorders, will frequently develop emotional or adjustment problems in addition to their neurological deficit. The value of a complete study for every patient can hardly be overestimated.

A high correlation between mild neurological dysfunction and mild or moderately abnormal EEGs was found.

Even more important is another observation: treatment methods which are basically different may be effective in a given case, and it may not

matter very much whether anxiety is reduced by tranquilizers, by environmental manipulation or by psychological means. Any of these methods may be effective for some time and so give the impression of a remission or of a cure. However, lasting improvement will be obtained only by those approaches which take into account all or most of the needs of the individual as he functions in his environment.

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Summary

An outline of a child guidance program is given, where a comprehensive approach revealed a high percentage of mild organic abnormalities interacting with environmental factors. Drug therapy and modification of the environment were used in addition to psychotherapy in an attempt to integrate the children into the community. Cooperation with the schools and agencies as well as with private doctors and other resources was extremely helpful. The role of the clinic as a consultant to community agencies is also emphasized.

Appendix

Chart A

A series of tests was largely used, suggested by LAURETTA BENDER and associates [POLLACK and KRIEGER, 1958], referred to as 'soft neurological signs'. They include the following:

1. Extension of arms horizontally in front for 1–2 minutes:
   Normal: no or little change in position;
   Positive: drift downwards, choreiform movements, convergence or divergence of arms, quivering of fingers, difference in height between arms or hands.
2. Hand grip: Normal: steady;
   Positive: any change in strength except for the normal tiring, quivering, irregularity, spurts, abnormal position of fingers.
3. Coordination: Face-hand-test, finger-finger-test, Tandem gait, Alternating and complex movements, Catching a ball: irregularities are counted.

4. Right-Left orientation: Ask the child: which is your right hand, foot, ear etc.? then: which is *my* right hand etc.?
5. Right or left- handedness.
6. Eye movements: Nystagmus on extreme movements.
   Convergence: test with pencil near and far, then cover one eye and watch for conjugated movement. Move pencil up and down and in circles.
7. Vision for both eyes separately, visual fields, reading tests.
8. Hearing tests
9. Speech
10. Hand writing
11. Whirling: Let the child stand with both arms extended in front and try gently to rotate the head.
    Normal: The child turns his head as long as pressure is exerted;
    Positive: Following of shoulders, rotating of upper body or hips or entire body. In extreme cases rotating continues on its own vigorously until stopped. Lordosis, following of one or both arms, wide divergence or convergence or overlapping of arms, lagging of one arm, flexion of the arm next to occiput, swaying, elevation of one or both arms.

The test is significant only in children over eight years, as it indicates the degree of maturity of the nervous system. It should always be considered as a help for diagnosis only, not as an infallible sign.

It is often positive in children with schizophrenia or with organic brain damage; primary behavior disorders or neurotic cases respond largely normal.

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Author's addresses: H. KOHN, M. D., 47 Pleasant Avenue, *Passaic, N. J. 07055,* and H. CHODOSH, M. D., 707 Broadway, *Paterson, N. J. 07514* (USA).

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A Treatment Strategy of Dealing with an Entrenched Long Hospitalized Patient Group [1]

ANNA R. PANDISCIO

Boston State Hospital, Boston, Mass.

Introduction

Throughout the mental health field, it is generally recognized that the days of the traditional mental institution are numberd. The case has been succinctly stated: 'Isolation and banishment are contrary to the objectives of fostering resocialization' [2. p. 501]. That is, the rural 'funny farm', convenient dumping ground for social embarrassments, can have no place in a society which accepts as its own the problems created by mental illness.

A keynote of the large scale hospital reorganizations now in progress is *community involvement.* The creation of Home Treatment, General Practitioner and similar programs attempts to combine institutional and community resources in a preventive approach. Volunteer and case-aide programs bring the outside world to the institutionalized patient as well as educating community members. The day and night hospitals and the Halfway Houses provide the mentally ill individual with a refuge in which to regain his equilibrium while keeping him at least partially involved with the world to which he is expected to return. All these facets of reorganization are directed away from isolation and banishment, towards a more responsible, resolute and hopeful view of the mentally-ill.

Yet in the middle of the new transition period to what is dimly envisaged as 'therapeutic society' [1] stands the chronic, long-entrenched

[1] My deep thanks and appreciation to MARGARET C. PROUTY for her editorial assistance in the writing of this paper.

patient. The product of a system which, for perhaps as many as fifty years of his life, has kept him regressed, isolated, and dependent, the long-term patient does not fit into present administrative plans. Mental health workers are faced with the problem of how to include large groups of such chronic patients in a rehabilitive setting without retarding the development of that setting and – quite often – the problem is judged insolvable.

The following is one worker's experience in dealing with a group of such institutionalized individuals. Chronic, entrenched patients, occupying a service which was supposedly to be part of a community mental health center, were involved in a treatment strategy which postulated only two things: firstly, that the patients were in one way or another to leave the service; and secondly, that the patients were capable of becoming involved in plans for their future. Such a relatively simple treatment basis nevertheless involves a wealth of assumptions concerning not only traditional views of the chronic patient but also the part played by staff attitudes in perpetrating or changing the custodial system. By describing why such a basis was chosen in this case and how the two decisions were carried out, I hope to outline a general treatment strategy for the chronic entrenched mental patient.

In August 1965, I arrived at Boston State Hospital as part of a large-scale Hospital Improvement Program. Built in 1839 in Dorchester, a sizable distance away from the center of population, Boston State functioned throughout the nineteenth century as a small agricultural community; the area's 'unfortunates' and the hospital staff lived and worked together in what has been called the 'humanitarian' era of American mental hospitals [1]. Towards the early 1900's, however, as the city reached into what had been a rural area, the patient census rapidly increased; overcrowding and lack of sufficient staff took their toll, and Boston State entered the 'dark ages' of custodial institutional care.

At present the Hospital is attempting to break the custodial pattern. Under the direction of Dr. MILTON GREENBLATT, now Massachusetts Commissioner of Mental Health, Boston State was organized into a number of units serving distinct geographical areas. This unit system, providing separate acute and chronic services to several communities, is designed to facilitate close cooperation between hospital and community workers in an intensive preventive and rehabilitive effort. In other words, Boston State Hospital has entered the aforementioned 'transition period', faces the enormous task of getting the community and the mental patient interested in one another.

My part in the reorganization was to be the setting up of a night hospital for the Dorchester Unit. Here, individuals able to function in the workaday world, yet not stable enough to be full-time members of the outside community, could work during the day and return to the hospital's supportive atmosphere at night. It was explained to me that the 'night hospital' already existed, in terms of a better-than-average building housing mostly working patients, but that further organization would probably necessitate moving some patients, especially those without jobs, from the building.

Along with this explanation went the following statistics: 'S' building was occupied by fifty-one patients, seven males and forty-four females, ranging in age from 17–83 years. The patients' length of hospitalization ranged from 4 to 48 years, the number of separate hospitalizations varied from the 17 patients with a first and only admission to Boston State, to the one patient with 10 hospital admissions. It was obvious just from these numbers that the 'night hospital' was at present occupied by a chronic population.

Of the several roads I could have taken to become personally acquainted with 'S' building, I chose to become knowledgable through the patients. My observations were of a population composed of individuals like the following:

> Mrs. K. was a 58-year-old woman, fairly attractive, neat and quiet, well liked by both staff and patients. She evidenced no overt thought disorder though she frequently complained of headaches. She was helpful on the ward and worked in the Hospital cafeteria. She saw her family frequently, visiting their nearby home most weekends. *Mrs. K. had been a patient at Boston State Hospital for fifteen years.*

Almost every 'S' building case study read this way: Good contact, no trouble on the ward, able to care for themselves, working usually in a hospital industry, yet definitely chronically hospitalized. Further investigation revealed that most of these patients had been placed in 'S' as a reward for 'good' (meaning untroublesome) behavior; and that previous attempts at their dehospitalization had been thwarted by their extreme antagonism towards anyone interfering with what had become, for these patients, a comfortable way of life. The patients' skill at resisting all efforts to make them leave Boston State had convinced the building's staff, who seemed content with the *status quo* chronicity. In other words, the 'night hospital' therapeutic bridge to the community was occupied by products of a system that had taught them to resist the community. The 'S' patients were

well-adjusted, but to the role of permanent mental patients in a permanent institutional setting.

In terms of the original plan for the night hospital, and considering the valuable contribution such a service would make to a community mental health center, there was only one alternative in dealing with the present occupants: These patients had to leave 'S' building. This administrative decision began the 'treatment strategy'; straightforward as it sounds, it was by no means an easy decision. Herein lies my first point. Every mental health worker dealing with patients such as I have just described must recognize and be aware of, first, the extreme chronicity present, and second, the danger of the feelings aroused in him by this chronicity. It would be a hard-hearted person who would feel no guilt over the custodial system that produced the 'S' patients; who would not be tempted to accept the *status quo* and let these patients live out their institutionalized lives. Yet to give in this way is not only to slow down the development of better mental health facilities, but to weaken the very premise that isolation and banishment are *not* the answer for *any* mentally-ill individual. Thus the decision to dehospitalize the 'S' building patients, and the firm administrative backing which this decision received, must be viewed as directed towards the welfare both of the institution and of the individual patients concerned.

A second decision involved in the treatment strategy for 'S' building was that concerning the method of dehospitailization. The simplest and quickest means of clearing the way for the night hospital would have been more administrative moves, that is, deciding *for* the patients where they were to go. However, though these patients all fitted well into their present chronic role, each one had been brought to the hospital by unique problems and needs; a cold-hearted administrative placement would have had little rehabilitive effect on the individual. Nor would Boston State Hospital have benefited. A blind placement for many 'S' patients would have been merely a transfer to another part of the Hospital, and of those placed in the community without follow-up, a sizable number would inevitably be readmitted.

Again, keeping in mind the welfare both of the institution and the individual, there seemed to be but one alternative: to work *with* these patients on their fear of leaving the security of the Hospital for a hitherto painful outside world. This strategy can be stated concisely as striving towards the patient's involvement, internalization, and identification; involvement in plans and responsibility for his future; internalization of his

fears and thus the beginnings of his mastery of those fears; and some identification with a worker who could demonstrate the ability to decide, bear, and follow through.

In other words, my treatment strategy consisted of rocking the existence of these long-term patients. The decision to work with them, involving of necessity a direct challenge, support in handling their anxiety, and aftercare which would prevent their equation of dehospitalization with rejection was aimed at awakening their hope, which to all appearances had been destroyed by the custodial system.

Herein lies my second point. The mental health worker faced by overwhelming chronicity must remember that these patients are products of a system; that they were first hospitalized fighting their illness, but that a succession of disappointments brought them to an isolated and dependant state. One may well ask how extensive is the identification potential in a chronic patient? What is his capacity for internalizing fear, and how much responsibility can he take for his own future? Yet to move and attempt to rehabilitate individuals such as occupied 'S' building, none of these doubts can be communicated to the patient; firm presentation of the decision to dehospitalize must be accompanied by rebuilding of the patient's self-esteem. The worker must demonstrate to him a convincing confidence in the capability for making life decisions.

Working with the fifty-one patients in 'S' building involved seeing them all on an individual basis. In August 1965, without having been introduced to the patients as a group, I began interviewing them individually. I stated to each that I was the new social worker in the building, that I was seeing him in order that we together could make plans for his present and future, and that our plans would involve his leaving the 'S' building. The patients' initial reactions were convincingly and universally hostile, suspicious and resistive. Most of them stated that they would not be able to leave the hospital and that I was mean and heartless to make them leave 'S' building.

These interviews, the patients' reactions to me and I to them, set the tone for a year-long dehospitalization process and follow-ups which are still today in progress. The method can best be described as treatment of the ambivalence felt by both staff and patients and centering around the patients' leaving 'S' building. One side of this ambivalence was hope, that the patients could and must leave. The other side, felt by the patients and staff as anxiety, represented the seeming hopelessness of chronicity, the fear of another defeat and disappointment. The treatment process consist-

ed of clinging to the hope, and acknowledging and handling the feelings of hopelessness.

The patients were met with the positive and hopeful from the first, in that their leaving 'S' building was presented as a fact. Their contentions of being unable to leave were met with, 'Perhaps, but you *must*'. Over and over again, when faced with my own doubts and the misgivings of the staff and patients, the decision was literally clung to. Patients' families, who had long ago given up their responsibility to the hospital, were helped to reassume this responsibility by becoming actively involved in concrete plans for their relative's future. The first actual discharge, and the fact that this patient continued to see me on an aftercare basis, came to be viewed by patients and staff as proof that dehospitalization was a not-so-fearful reality. Adding to the reality was the admission unit's pre-arranged refusal to readmit any discharged patient without first checking with our service. Thus, an active, direct, reassuring, and firm handling of this side of the ambivalence served to enlist the support of the staff; involve often hostile and fearful families; and direct the patients' energies away from manipulation and towards facing their fear of leaving the hospital.

Handling the other side of the ambivalence involved both acknowledging the patients' real fears and working to help them bear this anxiety. Their assertions that I was mean and heartless, which was as good as saying they were not worth my time, were met by, 'Perhaps, but I'll be seeing you anyway'. Throughout treatment the patient was assured that his fears of leaving were not only normal but that it was healthy to be able to express them; that by recognizing and discussing the fear, he would be better able to control it. The high expectation (dehospitalization) set from the beginning resulted inevitably in periods of regression; it was important, in helping the patient through these times, to help him understand that I could bear the regression in and with him. In the same way, a conscientious follow-up was necessary, to help in the transition to a new locale and to reassure the patient that his discharge was not another form of rejection. This aspect of the treatment, handling the ingrained chronic hopelessness, required the most work on both sides; yet the work produced results which must be viewed as immense achievements in the lives of those 'good', untroublesome patients.

In September, 1966, thirteen months after my arrival at Boston State Hospital, all fifty-one patients were discharged from 'S' building. Of the forty-one who returned to the community, thirteen are living alone and completely caring for themselves; three are living with their families, three

are living alone and working within the hospital; four are living in an apartment sponsored by the hospital[1]; one is on family care and one is living in the Half-way House. Sixteen patients were discharged to nursing homes and of these, one died.

Of the ten patients transferred to other buildings, four were randomly selected for a special nursing project and three of these have been discharged to the community. The other six patients remain in the Hospital.

'S' building, now renovated, is being staffed as a night hospital equipped to handle crisis situations throughout the surrounding community. From the above statistics, it seems that the renovation has been accomplished not at a cost to the building's former occupants but at a gain.

Conclusion

A brief review of this work at Boston State Hospital, of the decisions, assumptions, and methods involved in the dehospitalization of the 'S' building patients, outlines my proposed treatment strategy for the long-entrenched mental patient. Two decisions were made. The first, that the patients were to leave, received firm administrative backing and was presented as a *fact*; strict adherence to it, in the face of my own and 'S' building's guilt, doubt, and resistance, provided a valuable therapeutic tool in mobilizing staff, families, and patients. The second decision, to work *with* instead of around the patients on their leaving, required equally strict adherence; the program of challenge, support, and aftercare entailed commitment, hard work, and hope not usually reserved for the chronic individual.

Evolving the two aspects of this strategy required, first, an awareness of the worker's own feelings, reminders of the snake pit do little for one's peace of mind, and the necessity of moving its products can be a threat to the staff as well as the patients. Yet along with this awareness was a strong belief in the means and goals of the community mental health movement – a belief not only that new services are necessary, but that however overwhelmingly chronic are these products of the custodial system, present hopefulness and responsibility can be applied to them as well as to the less institutionalized patient.

[1] The generous support of M. THEODORE SCHONFELD, Vice-President of Zayre, Inc. and founder of the PROP industrial workshop at Boston State, enabled us to set up and continue to maintain this apartment.

Summary

This paper describes an administrative approach that outlines a social worker's proposed treatment strategy involved in the dehospitalization of 51 long entrenched patients. Two decisions were made. The first, that the patients were to leave, received firm administrative backing, and was presented as a fact, strictly adhered to. This provided a valuable therapeutic tool in mobilizing staff, families, and patients. The second decision, to work *with* instead of around the patients on their leaving, required equally strict adherence; the program of challenge, support, and aftercare entailed commitment, hard work, and hope, not usually reserved for the chronic individual.

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Author's address: ANNA PANDISCIO, The Commonwealth of Massachusetts Department of Mental Health, 15 Ashburton Place, *Boston, Mass. 02108* (USA).

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Body, We-awareness, and Therapeutic Community

E. W. Eng

Veterans Administration Hospital, Lexington, Kentucky

'Let us imagine a body full of thinking members'
Pascal (473)

The present interest in 'therapeutic community' has a variety of meanings. If it refers to a practical method of psychiatric treatment, it also means that the community can be therapeutic, which also hints at that more inclusive community from which the patient is removed when he enters a psychiatric hospital. Sometimes 'therapeutic community' is taken to mean that the healing efficacy of the hospital stems from the common purposes of patients and staff members. If it were the purpose of this paper to explore the possible meanings of the notion of therapeutic community, an entire book would be necessary. My present aim is more modest. For the present I only wish to make the notion of 'therapeutic community' meaningful for work in a hospital in a rather more fundamental way than is usually the case. For while it is apparent that a hospital is concerned with bodily care (and the care of bodies), it is not at all clear how the community of patients, not to speak of both patients and staff, constitute a 'therapeutic milieu'. Medical interventions, medications, and medical attitudes, along with the ministrations of nurses and their assisants, often seem sufficient to account for the healing effects of the hospital without reference to patients' relationships with one another, staff members' relationships, relationships between patients and staff members, or the relation of the hospital and its culture to the society and culture surrounding it. Yet the development of interest in 'therapeutic community', during the past fifteen years in particular, places upon us the responsibility of gaining a more fundamental understanding of what makes therapeutically effective this paradoxical emphasis on community for those who have failed or been rejected from the larger world 'outside'. I do not believe it sufficient, for

reasons that I hope will become clear later, to derive its presence simply from the innovation of tranquilizing drugs. For even though this discovery may have played a necessary part in enabling the therapeutic community, it is insufficient to account for developments subsequent to this new control of symptoms. Nor is the notion of therapeutic community new in history.

It seems to me that a more fundamental understanding of the problems and opportunities of therapeutic community in the psychiatric hospital (at the very least) can be gained from a more careful consideration of the relationships between the lived or own body and community.

Some clarification of terms is in order here, since I use 'body' and 'community' in a reciprocally implicating fashion[1]. A word or two about the lived body, i. e., 'own body'. First of all, I do not mean 'my own body', since the body to which I am referring is not invariably an object of possible possession. As 'own body' it may be experienced as either subject or object, either in relation to me or to others. 'Own body' may have me as an object as when I am racked by pains I can neither attribute to an external source nor to a localized organ. I may have the 'own body' as object when I embrace another demonstratively. Or 'own body' may be a subject in relation to another 'own body', as when my own blush elicits a blush from another; once again 'own body' may be an object of another 'I' if I experience it as the object of another's intention.

Some languages have words for the 'own body', as contrasted with the body that is impersonal. These words usually contrast the 'live' with the 'dead' body. German contrasts the 'Leib', cognate with 'life', with 'Körper', cognate with 'corpse'. In Greek there is, for a certain time at least, a contrast between the 'soma', the material body, and 'demas', the living body. In French, the own body has been rendered by 'corps propre' or 'corps sujet' (MERLEAU-PONTY), although this latter expression does justice only to the nominative case of the declension of the own body.

Community, in the sense in which I am using it here, is simply the immediate sense of shared experience as this is present in facing one another. It is a directly grasped understanding. It comes to mean that a relationship like that of parent and child, doctor and patient, teacher and student, in its lived incompleteness, attests to a larger whole on which identities such as parent, child, teacher, etc. depend. It is, in the fullest sense, 'we-awareness'.

[1] By 'reciprocally implicating' I imply that the separate terms emerge and divide from a less differentiated level of awareness, and remain interdependent.

Now it has been the conventional lot of most persons who become 'mental patients' to have failed in one or more of the 'roles' whose successful performance is the condition of being retained as a member of the larger society and its culture. Conventional society expects of its members a certain level of proficiency in certain roles at certain ages, and usually provides little assistance, once failures have accumulated beyond a certain point. Then, ostensibly to protect the working arrangements of the social order, those who have not met the requirements are removed from society, if they have not already removed themselves.

It is at this point that the child or adult who fails in achieving a certain level of meaningful relationships develops a variety of bodily disturbances, whether in the form of stomach distress, postural difficulties, sexual problems, various addictions, or a shifting spectrum of bodily complaints. It is these reactions that initially qualify the patient for medical examination.

At this point a crucial point is usually overlooked. The 'body' examined by the doctor is not the same as the 'body' known by the patient. It is one in which he is living and which he lives, while the body examined by the doctor is pre-eminently an anatomical and physiological construct, however the doctor may empathize with the patient. It is just this discrepancy that accounts for the way in which the patient's body comes to be experienced by both doctor and patient as an obstacle that stands in the way of the patient *learning* anything new, now that it has become the common, collusive, and *uncomprehended* focus of attention for both doctor and patient, while at the same time it stands outside their we-relationship. On the one hand, the patient's body is being treated in an apparent community of interest, i. e., 'getting well', while at the same time 'body' and 'community' are considered as mutually exclusive. Now if, as is often the case, we experience this situation as an impossible one, it argues that a more effective healing situation is one that involves a we-awareness in which body and community are somehow continuous.

There are other reasons for adopting this view. All of them compel us to alter our usual ways of thinking about the body and about community. It may be valuable for the time being to reverse our usual thinking about the relationship of body and community, and then, in turn, to modify our accepted ways of thinking, once 'body' and 'community' have been restored to the everyday world of I-world relationships.

If we start with 'community' as we-awareness, we can recover the 'own body' which so often becomes lost from sight for both patient and doctor during the development and treatment of psychiatrically-defined

illness. Nor is it sufficient to point out that the psychiatric patient has lost touch with his 'own body' to justify his treatment as bodily in the object sense. In any event, the evidence – which we cannot review here – seems compelling that it is from a matrix of lived community that the own body emerges. Now this 'own body' remains initially within the penumbra of the lived community. This of course is quite the reverse of the way things customarily appear. From the standpoint of the more clearly defined 'own body', it is the community which appears to fall within the shadow and protection of the manifold inhabitants of the separate bodies. Such an order or priority must nevertheless be seen as an effect of reversed temporal perspective resulting from having begun with the constituted outcomes of a still vital situation. It was from the mother's lived community with her offspring that the infant eventually emerged with its own body. There is no reason to assume that this priority of community over lived body ever ceases, despite decreasing openness to new experience with age.

Strictly speaking, the community of the world is established before the body emerges as an enclosed 'community' within this larger community, in one sense as an embodiment of it. Only from the matrix of lived community, of which the world is a primary form, already constituted, can there emerge an own body, still open, then *my* own body, and finally *the* body or *a* body.

But it is important to note that this does not make what we call 'society' simply generative of the individual. Rather, we might say that the power of the belief that society generates the individual stems from an unclear perception of this dependency of the own body from lived community. But this relation precedes the constitution of society as such. The community that is prior to the realization of the own body is insufficiently differentiated to be considered a causal agent; it is rather more like a partner whose meaning is still not clear. Such a community might be called 'operative' in contrast to 'thematic'[2]. The character of 'operative' would also be true of the own body within such a community.

It is because the body at the operative level embodies the operative community, prior to any explicit differentiation of self and other, that the community is able to be therapeutic, i. e., integrative, for someone who presents a facade of physical complaints and/or disorders. We may, it

[2] The distinction is from EUGEN FINK. I prefer this distinction to that of 'thematic' and 'non-thematic', because of its emphasis on the active character of the non-thematic in this instance.

seems to me, also understand the psychotic losses of body to the world and to others on much the same basis, though this would require a separate discussion.

An important feature of the community as operative is that any dissonance within it will resonate at the level of the operative body. Incompatible feelings in the operative matrix will be reproduced in the operative bodies comprising this matrix[3]. It is precisely the implied requirement of consistency in attitude among the staff of a therapeutic community that has been recognized in the recent and current interest in 'attitude therapy'. It is doubtful whether this pragmatic emphasis on a single device is enough, particularly where other conditions necessary for insuring consistency are absent. In any event, continuous changes in power structure and personnel make it difficult for patients and staff alike to maintain a vigorous, active we-awareness without a constant struggle.

This we-awareness must be renewed if men are to remain in responsible touch with their changing human surroundings and conditions; when they are unable to achieve this renewal, their world itself becomes bodily in the direction of becoming a quasi-intentional subject. The human surround tends to assume the characteristics of a body, in its ability to influence us without intervention of our own deliberate judgment, much as in hypnotic states. As such, this is obscene, i. e., relegated to the sphere of disowned body, outside the sphere of operative community and operative body [ENG, unpublished paper on the obscene in art and society: Undoing the Medusa. DIAS Meet. 1966].

A convulsive effort to win back meaning by yielding to such an oracular disowned body can lead to the disruptions of psychosis. Psychosis is used here to refer to experiences in which the own body fuses with memory to take priority over all experiencing as rooted in the world. As such it might more suitably be termed 'somatosis', since it is intrinsically characterized by bodily autism[4].

Now it could be said to all of the foregoing that what I have emphasized is simply that communication is important for teamwork in a psychiatric hospital. If this were true, then what I have written would be superfluous. But the usual presentations of communication in the hospital tend to ignore

[3] The classical evidence for this is the Stanton-Schwartz effect according to which the duration of episodes of psychotic excitement in patients is related to that of disagreement among staff members in contact with the patient [see: STANTON and SCHWARTZ, 1954].

[4] 'Somatosis' is a term derived from FRANKL, in a context I do not recall.

the ways in which a one-sided natural science attitude in medicine interferes with the formation of we-awareness. Such presentations also fail to consider the communicative significances of what are taken as merely objective forms of medical intervention, namely medication and shock treatments, as well as the professional interventions of social workers and psychologists. What is customarily omitted is any recognition of the own body and its linkage with we-awareness. Such a linkage is central for instituting and understanding the action of the therapeutic community. I have briefly tried to show the value of distinguishing the operative from the thematic body, and how the 'own body' is actively brought out within the we-awareness of an operative community.

Summary

The relationship between the world of the 'body subject' (corps propre, gelebter Leib) and the patient's participation in a ward community is discussed. Understanding of this relationship enables more intelligent guidance of the therapeutic community.

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Author's address: E. ENG, PH. D., Veterans Administration Hospital, *Lexington, Ky. 40507* (USA).

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